

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11773

CERTIFICATE OF DEATH

117654
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS <u>1</u>		(If rural give location)	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Wesley</u> (Last) <u>Anderson</u>				4. DATE OF DEATH: (Month) <u>Dec.</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>3-2-1863</u>	
				9. AGE last birthday: <u>93</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>labour</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>unk -</u>		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>John Anderson</u>				14. MOTHER'S MAIDEN NAME: <u>Martine Sugar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>4 no</u>				16. SOCIAL SECURITY No.: <u>unk</u>		17. INFORMANT & ADDRESS: <u>Lucille Johnson - St. Michaels, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
443X Immediate cause (a) <u>arteriosclerotic cardiovascular disease</u>						20 & 400	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>hypertension; endarteritis obliterans feet;</u>							
(c) <u>Ch. myocorditis; — senility</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>1935</u> , 19....., to <u>31 Dec</u> , 1955, that I last saw the deceased alive on <u>30 Dec</u> , 1955, and that death occurred at <u>12:25 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Dr. J. H. Hargett</u>				ADDRESS <u>St. Michaels</u>		DATE SIGNED <u>12/31/55</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, of county) (State)	
<u>Burial</u>		<u>1-3-56</u>		<u>St. Luke's</u>		<u>St. Michaels, Carroll Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 2, 1956</u>		<u>C. Harry Warr</u>		<u>Walter H. Hargett</u>		<u>St. Michaels, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

11766

STATE DEPARTMENT OF HEALTH

MARYLAND

11774

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitburg</u> TOWN <u>Fruitburg</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer Park Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fruitburg</u> TOWN <u>Fruitburg</u> STREET ADDRESS (If rural, give location) <u>Deer Park Rd. RFD #1</u>	
3. NAME OF DECEASED (First) <u>LEE</u> (Middle) <u>MILFORD</u> (Last) <u>BAILEY</u>		4. DATE OF DEATH (Month) <u>December</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 17, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days Hours Min
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Lincoln Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Chilcoat</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>176-65-3167</u>	
17. INFORMANT AND ADDRESS <u>George Bailey, RFD #1 Fruitburg, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Carcinoma, liver</u>			
Antecedent cause(s) (b) <u>156.1</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 8</u> , 1955, to <u>Dec 2</u> , 1955, that I last saw the deceased alive on <u>Dec 2</u> , 1955, and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Carroll E. McWilliam M.D.</u> (Degree or title)		ADDRESS <u>Leicester, Maryland</u> DATE SIGNED <u>Dec 2, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE <u>Dec 5-55</u> NAME OF CEMETERY OR CREMATORY <u>Carroll Reform</u> LOCATION (City, town, or county) <u>Faithful Pa.</u>	
DATE REC'D BY LOCAL REG. <u>12-3-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u> 24. FUNERAL DIRECTOR <u>J. F. Eline Sons</u> ADDRESS <u>Rustington, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 6 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11775

CERTIFICATE OF DEATH

11767

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md.</u> COUNTY _____		CITY (If outside corporate limits, write RURAL and give nearest town) _____		TOWN _____	
CITY (If outside corporate limits, write RURAL and give nearest town) _____		LENGTH OF STAY (in this place) _____		CITY (If outside corporate limits, write RURAL and give nearest town) _____		TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		STREET ADDRESS _____		CITY <u>Baltimore City</u>		TOWN _____	
15 <u>Springfield State Hosp.</u>		523 S. Kenwood Ave		3601-4		✓	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Marie Baldwin</u>				<u>Dec. 25 1955</u>			
5. SEX <u>fem.</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>mar.</u>	8. DATE OF BIRTH <u>4-12-1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James Ross</u>			
14. MOTHER'S MAIDEN NAME <u>Florence Bishop</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) _____			
16. SOCIAL SECURITY NO. _____				17. INFORMANT & ADDRESS <u>records of Springfield State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
334X IMMEDIATE CAUSE (A) <u>Chronic brain syndrome associated with</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>circulatory disturbance, cerebral arteriosclerosis</u>						more than 10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>with psychotic reaction.</u>						3 yrs	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>diabetes</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____	
21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>July 25</u> , 19 <u>52</u> , to <u>Dec. 25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 25</u> , 19 <u>55</u> , and that death occurred at <u>8:17 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>			
DATE <u>Dec. 26, 1955</u>				DATE SIGNED <u>Dec. 26, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		LOCATION (City, town, or county) <u>7225 EASTERN BLVD., MD.</u>	
24. REC'D BY REGISTRAR <u>DEC 27 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Sherris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Giller</u>		ADDRESS <u>9015 CONKLING ST. BALTO., MD.</u>	

CERTIFICATE OF DEATH

Form No. 100

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11767

CERTIFICATE OF DEATH

12555

76

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MD.</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>13 YRS.</u>		CITY OR TOWN <u>WESTMINSTER</u>		CITY OR TOWN <u>WESTMINSTER</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>165 E. GREEN</u>		STREET ADDRESS <u>165 E. GREEN</u>		STREET ADDRESS (If rural give location)		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH HENRY BANGE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 31 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>OCT. 21-1877</u>	
9. AGE last birthday <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>SIMON BANGE</u>			
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-03-7501</u>				17. INFORMANT & ADDRESS <u>DAISY BANGE 165 E. Green Westminister, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>19.55</u>			
ANTECEDENT CAUSE(S) DUE TO <u>With myocardial degeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerosis & mild</u>				General <u>yes</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fractured ribs</u>				FEB 11-1954			
19a. DATE OF OPERATION <u>1 Feb. 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Hard heart, Transcatheter</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>FEB 11, 1954</u> , to <u>Dec 31, 1955</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>11:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William Specker</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminister Md</u>		DATE SIGNED <u>1/3/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 4. 1956</u>		NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEM. BELLETERSTOWN, MD.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albanard Son Westminister, Md.</u>		ADDRESS	
DATE <u>1-6-56</u>							

CERTIFICATE OF DEATH

FILE NO. 100-10000

1. NAME OF DECEASED (Print or Write)

DATE

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

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CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

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CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

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IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

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DATE OF BIRTH

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IMMEDIATE CAUSE

INTERMEDIATE CAUSE

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PRE-EXISTING DISEASE

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CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

AGE

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RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE OF BIRTH

PLACE OF BIRTH

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MANNER OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF REPORT

REPORTED BY

SIGNATURE

11776

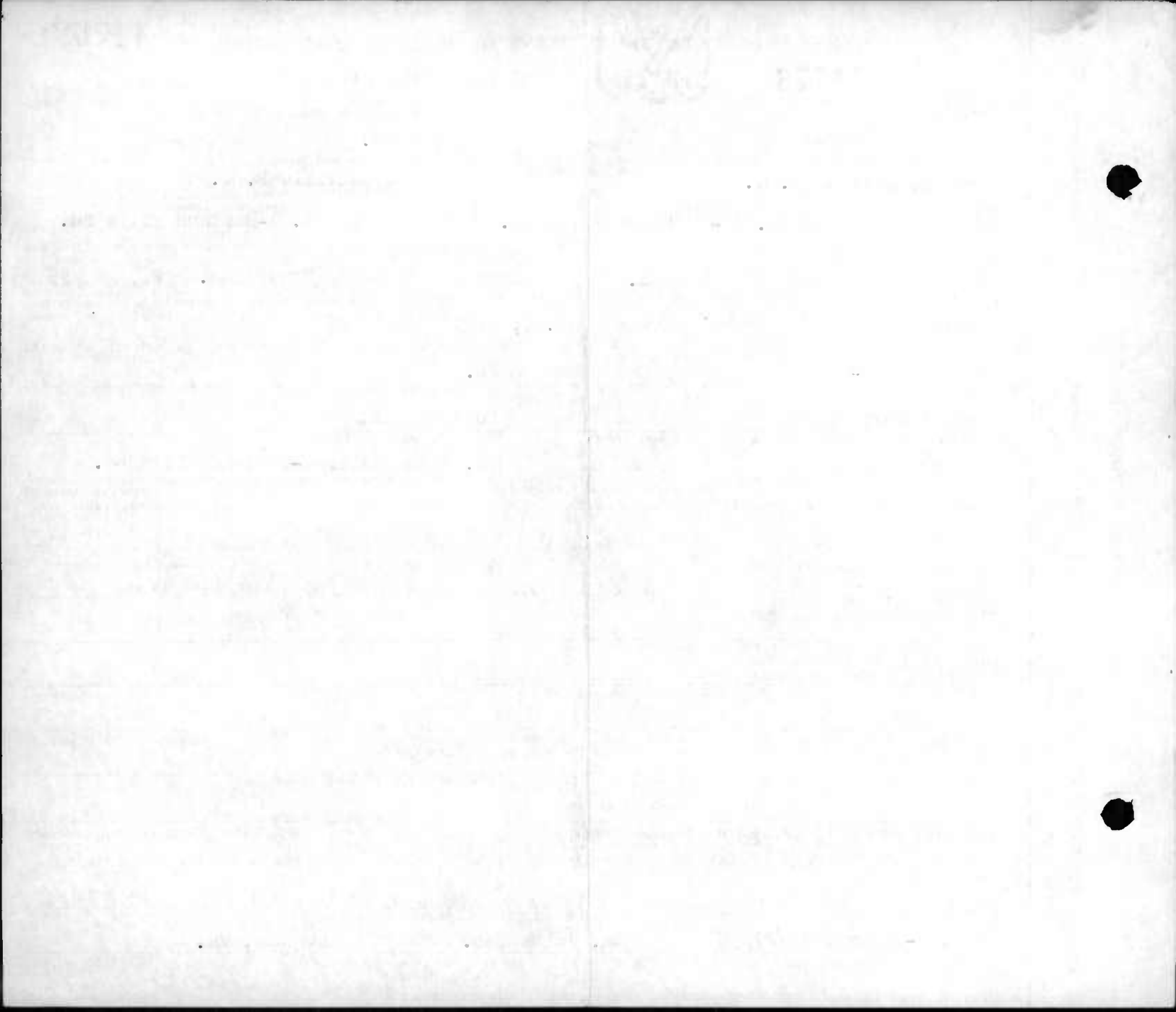
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville P. O.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville P. O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route No. 1 - Oakland Mills Rd.</u>				STREET ADDRESS (If rural give location) <u>Route No. 1 - Oakland Mills Rd.</u>			
3. NAME OF DECEASED: (First) <u>ANNIE</u>		(Middle) <u>E.</u>		(Last) <u>BARNEY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 27, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Nov. 7, 1863</u>		9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>James Sanders</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca Todd</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ruth Gisburne-Oakland Mills Rd.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio-vascular Disease</u>							
ANTECEDENT CAUSE (B) <u>Arteriosclerosis & Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/26, 1955</u> , to <u>12/27, 1955</u> , that I last saw the deceased alive on <u>12/26/55</u> , 19 <u>55</u> , and that death occurred at <u>12/26</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Thos. E. Martin</u>				ADDRESS <u>M. D. Paudalltown, Md.</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial-removal</u>		DATE THEREOF <u>12/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Johns Cem.</u>		LOCATION (City, town, or county) (State) <u>Hampton, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Thos. J. Tickers & Sons - Balt. & Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



11769

MARYLAND STATE DEPARTMENT OF HEALTH

11777

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERSReg. Dist. No. 70
80

1. PLACE OF DEATH- COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TANEYTOWN RURAL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TANEYTOWN RURAL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>BETTY ELIZABETH BAUERLIEN</u>		4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>MAY 15-1932</u>
9. AGE last birthday <u>23</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cartridge Rubber</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE MOSER</u>		14. MOTHER'S MAIDEN NAME <u>HELEN GRIMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>220-28-7968</u>	
17. INFORMANT <u>HELEN MOSER - WOODSBORO RURAL</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>981X</u> Immediate cause (a) <u>Gunshot wound head and chest</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office, bldg., etc.) INJURY <u>Home</u> (CITY OR TOWN) <u>Rural Taneytown</u> (COUNTY) <u>Carroll</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) INJURY <u>12</u> <u>12</u> <u>55</u> <u>10</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Shot in head and chest with rifle</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>James J. Monahan, Deputy Medical Examiner</u>		DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec 15-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt Hope</u>		LOCATION (City, town, or county) (State) <u>Woodboro Md</u>	
DATE REC'D BY LOCAL REG <u>Dec 14/55</u>		24. FUNERAL DIRECTOR <u>Powell & Hartzler Woodboro, Md</u>	
REGISTRAR'S SIGNATURE <u>Ethel M. Mehreng</u>		ADDRESS <u>Local</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 19 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11770

CERTIFICATE OF DEATH

Reg. Dist. No. 26

Item 2. Film 11768 1-23-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westminster</u>		<u>Alten Life</u>		TOWN <u>Westminster Md.</u>		27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<u>Center St (Deer Crossing Lane)</u>				<u>Pennsylvania</u>		<u>Center St (Deer Crossing Lane)</u>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>JANE</u> (Last) <u>BAUST</u>				(Month) <u>Dec</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>f.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 16, 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
				<u>Carroll Co. Md.</u>	<u>U.S.A.</u>		
13. FATHER'S NAME <u>David H. Wardlaw</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Reyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Harold M. Wardlaw Westminster Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>12-11-55</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension & Arteriosclerosis</u>				<u>Several yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Vascular Heart Disease</u>				<u>Several yrs</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 19, 1955</u> , to <u>Dec 19, 1955</u> , that I last saw the deceased alive on <u>Dec 19, 1955</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Speichers</u> M.D.				ADDRESS (Street, city, town, state) <u>Dec 20-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 22, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Westminster Cem</u>		LOCATION (City, town, or county) (State) <u>Westminster Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Herbert Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr.</u>		ADDRESS <u>Westminster Md.</u>	
DATE <u>12-21-55</u>							

BUREAU V. S.

DEC 22 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11771

11778 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>since 8-8-55</u>		TOWN <u>Monrovia</u>		<u>15-X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Windsor</u> <u>-</u> <u>BEALL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13th</u> <u>19 55</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 5, 1883</u>		9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>		11. BIRTHPLACE (State or foreign country) <u>Monrovia, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Caleb A. Beall</u>				14. MOTHER'S MAIDEN NAME <u>Margaret L. Watkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>3-4 days</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Generalized arteriosclerosis</u>						<u>more than 10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>---</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis with psychotic reaction.</u>						<u>more than 10 yrs.</u>	
19a. DATE OF OPERATION <u>---</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 10, 1955</u> , to <u>Dec. 13, 1955</u> , that I last saw the deceased alive on <u>Dec. 13, 1955</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>		LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Dec. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Henry Tucker</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u>		ADDRESS <u>Damascus, Md.</u>	

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BUREAU A. B.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11772

11779 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cannell</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Cannell</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Manchester Md</u>		X	
TOWN <u>Manchester Md</u>				TOWN <u>Rural, Manchester Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Manchester, Westminster Rd</u>				STREET ADDRESS (If rural give location) <u>Manchester, Westminster Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Peter</u> (Middle) <u>Biplex</u> (Last)				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Jan 5 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 Year Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Biplex</u>				14. MOTHER'S MAIDEN NAME <u>Friedella Mathias</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Earl Wentz, Westminster Md #3</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1 <u>422.1</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u></u>		21c. WHERE DID INJURY OCCUR? (City or town) <u></u> (County) <u></u> (State) <u></u>			
21d. TIME OF INJURY (Month) <u></u> (Day) <u></u> (Year) <u></u> (Hour) <u></u> M. <u></u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>48</u> , to <u>Dec 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>55</u> , and that death occurred at <u>11 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Buch</u> M.D.				ADDRESS (Street, city, town, state) <u>Hampstead Md</u>		DATE SIGNED <u>Dec 19 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburied</u>		DATE THEREOF <u>12/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		LOCATION (City, town, or county) <u>Manchester, Md</u>	
24. RECD BY REGISTRAR <u>Dec. 21-55</u>		REGISTRAR'S SIGNATURE <u>Mrs. W.P. Denner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Buch</u>		ADDRESS <u>Westminster Md</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. DATE OF DEATH

3. PLACE OF DEATH (PRINT OR TYPE)
 CITY AND COUNTY
 STATE

4. SEX
 5. AGE
 6. OCCUPATION

7. CAUSE OF DEATH (PRINT OR TYPE)
 8. MANNER OF DEATH (PRINT OR TYPE)

9. DATE OF BIRTH

10. PLACE OF BIRTH

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. PREVIOUS ILLNESS

15. PRESENT ILLNESS

16. MEDICAL HISTORY

17. PHYSICIAN'S SIGNATURE

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF CLERK

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF DISTRICT ATTORNEY

25. SIGNATURE OF COUNTY CLERK

26. SIGNATURE OF TOWNSHIP CLERK

27. SIGNATURE OF VILLAGE CLERK

28. SIGNATURE OF CITY CLERK

29. SIGNATURE OF STATE CLERK

30. SIGNATURE OF FEDERAL CLERK

31. SIGNATURE OF MARSHAL

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF DISTRICT ATTORNEY

34. SIGNATURE OF COUNTY CLERK

35. SIGNATURE OF TOWNSHIP CLERK

36. SIGNATURE OF VILLAGE CLERK

37. SIGNATURE OF CITY CLERK

38. SIGNATURE OF STATE CLERK

39. SIGNATURE OF FEDERAL CLERK

40. SIGNATURE OF MARSHAL

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF DISTRICT ATTORNEY

43. SIGNATURE OF COUNTY CLERK

44. SIGNATURE OF TOWNSHIP CLERK

45. SIGNATURE OF VILLAGE CLERK

46. SIGNATURE OF CITY CLERK

47. SIGNATURE OF STATE CLERK

48. SIGNATURE OF FEDERAL CLERK

49. SIGNATURE OF MARSHAL

50. SIGNATURE OF SHERIFF

BUREAU V. 8

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11773

11730 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>7 Mos. 26 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3701.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>3316 Harmony Court</u>		(If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Felicia</u>		(Middle)		(Last) <u>BOONE</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>2/7/88</u>	
9. AGE last birthday <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cuba</u>		12. CITIZEN OF WHAT COUNTRY? <u>alien</u>	
13. FATHER'S NAME <u>Phillip</u>				14. MOTHER'S MAIDEN NAME <u>Ella</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>2 days.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Diabetes Mellitus</u>						<u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>						<u>2 - 3 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/21</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/3</u> , 19 <u>55</u> , and that death occurred at <u>2:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeld</u> M.D.				DATE SIGNED <u>Sykesville, Maryland 12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>12/6/55</u>		<u>Forest Hill</u>		<u>Germantown Rd</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 6 1955</u>		<u>C. Gary Hays</u>		<u>J. J. Zaher</u>		<u>Loan</u>	

NOTIFICATION

1. This form is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, within ten days of the date of death. It is to be filled out in duplicate, and the original is to be retained by the Registrar, and the duplicate is to be returned to the physician or other person who has attended the deceased.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

FILED

IN THE OFFICE OF THE REGISTRAR

DATE OF DEATH

PLACE HERE NAME OF DECEASED

PLACE HERE ADDRESS OF DECEASED

PLACE HERE CITY AND STATE

PLACE HERE COUNTY

PLACE HERE SEX

PLACE HERE AGE

PLACE HERE OCCUPATION

PLACE HERE CAUSE OF DEATH

PLACE HERE MANNER OF DEATH

PLACE HERE SIGNATURE OF PHYSICIAN

PLACE HERE SIGNATURE OF REGISTRAR

PLACE HERE SIGNATURE OF WITNESSES

PLACE HERE SIGNATURE OF DECEASED

PLACE HERE SIGNATURE OF NEXT OF KIN

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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. For this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11774

11781 CERTIFICATE OF DEATH

Item 2, FilmGL90 12-28-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> ?		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>Rural - Sykesville</u>		<u>since 11-14-52</u>		<u>Baltimore</u> ?		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>Unknown</u> (If rural give location)			
<u>Found wandering in streets of Balto.</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Walker</u> <u>BOONE</u>				<u>December 13</u> <u>19</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>unknown</u>	<u>unknown</u>	<u>about 63</u> yrs.	Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>unknown</u>		<u>—</u>		<u>unknown</u>		<u>unknown</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>unknown</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unkn.</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>minutes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO						<u>more than 10 yrs.</u>	
(C) <u>---</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>more than 10 yrs.</u>	
<u>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		21. DATE OF DEATH	
<u>---</u>		<u>---</u>		<u>YES</u> <input type="checkbox"/> <u>NO</u> <input type="checkbox"/>		<u>12/13/55</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>---</u>		<u>---</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>---</u>		<u>---</u>		<u>---</u>			
22. I hereby certify that I attended the deceased from <u>January 22</u> 19 <u>53</u>, to <u>Dec. 13th</u> 19 <u>55</u>, that I last saw the deceased alive on <u>Dec. 13</u>, 1955, and that death occurred at <u>1:00 PM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>[Signature]</u>				<u>Sykesville, Maryland</u>		<u>12/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Unburied & stored</u>				<u>Univ. of Md. Med. School</u>		<u>Baltimore, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 19 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>---</u>	

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INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11782

CERTIFICATE OF DEATH

11775

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Henryton</u>		<u>7</u>		TOWN <u>Baltimore</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>3130 Belmont Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Phillip</u>		(Middle)		(Last) <u>Broughton</u>		(Month) <u>12</u> (Day) <u>10</u> (Year) <u>19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>10-31-15</u>		<u>40</u> yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Not employed</u>				<u>Maryland</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>4 No</u>		<u>None</u>		<u>Deceased</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>002X</u> IMMEDIATE CAUSE (A) <u>Cardiac insufficiency decompensated</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary tuberculosis, chronic</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 3</u>, 19 <u>55</u>, to <u>Dec. 10</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>Dec. 10</u>, 19 <u>55</u>, and that death occurred at <u>12:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>T. F. Neal</u>				<u>M. D.</u>		<u>Henryton, Md.</u>	
23. BURIAL, CREMATION, REMOVAE (SPECIFY)						DATE SIGNED	
<u>Burial</u>						<u>12-10-55</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-10-55</u>		<u>Albert R. Swankham</u>		<u>Holland Funeral Home</u>		<u>1631 Duval Hill</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11776

11783

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural - Sykesville</u>		<u>9 days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>512 Park Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>DANIEL</u> (Middle) <u>PATRICK</u> (Last) <u>BROWN</u>				(Month) <u>12</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Div.</u>	<u>5/21/84</u>	<u>71</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Parking attendant</u>		<u>unk -</u>		<u>Wisconsin</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Patrick Brown</u>				<u>Eleanor O'Hare</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>unknown</u>			<u>211-20-7557</u>		<u>Record, Springfield State Hospital</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						<u>5 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Syphilis, undiagnosed site</u>						<u>unknown</u>	
(C) <u>Pulmonary tuberculosis, far-advanced</u>						<u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>1 year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1</u> , 19 <u>55</u> , to <u>12/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>55</u> , and that death occurred at <u>1:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-16-55</u>		<u>New Catholic</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Dec. 15, 1955</u>		<u>C. Harvey Tucker</u>		<u>A. W. Moore - 805 N. Calvert St.</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11777

11784

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>16 days</u>		TOWN <u>Baltimore - 11</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2910 Huntington Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLOTTE</u>		(Middle) <u>AGNES</u>		(Last) <u>BYUS</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12/20/89</u>	
9. AGE last birthday <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Noxema Company</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Daniel O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Margaret O'Connor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-13-4206</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Pulmonary embolism</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma of left breast</u>				months			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Involuntional psychotic reaction</u>				2 months			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>11/28</u>				21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21H. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/28</u> , 19 <u>55</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>9:20 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Soumireu</u>				DATE SIGNED <u>12/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>12-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>	
24. REC'D BY REGISTRAR <u>DEC 5 1955</u>				REGISTRAR'S SIGNATURE <u>C. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwab</u>	
				ADDRESS <u>Sykesville, Maryland</u>		LOCATION (City, town, or county) <u>BALTIMORE MD</u>	

2007/11/11

RECEIVED
BUREAU V. S.
DEC 5 1955

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

REG. GEN. NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERGYMAN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INVESTIGATOR

18. SIGNATURE OF SUPERVISOR

19. SIGNATURE OF CHIEF OF BUREAU

20. SIGNATURE OF ASSISTANT CHIEF

21. SIGNATURE OF CLERK

22. SIGNATURE OF RECEPTIONIST

11785

11778

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 74

1. PLACE OF DEATH: <u>Springfield State Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY, <u>Carroll</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Near Sykesville, Maryland</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>TOWN Baltimore 27</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural, give location) <u>5610 Carville Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		5. AGE last birthday:	
<u>Joseph Edward Carew</u>				<u>12 7 19 55</u>		<u>73</u> yrs.	
6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday:		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Nov. 25, 1882</u>		<u>73</u> yrs.		<u>Months Days Hours Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Waterman</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Joseph Carew</u>			
14. MOTHER'S MAIDEN NAME: <u>Martha Schible</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>			
16. SOCIAL SECURITY No.: <u>217-141295</u>				17. INFORMANT & ADDRESS: <u>Mrs. Velma Pritchett, daughter</u>			
18. MEDICAL CERTIFICATION				19. DATE OF OPERATION: <u>12-10-55</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
Immediate cause (a) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>0 minutes</u>			
Antecedent cause(s) (b) <u>Myocardial Infarction</u>				3 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>12-10-55</u>				19b. MAJOR FINDING OF OPERATION: <u>---</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Shirley Barr</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>12-10-55</u>			
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>				LOCATION (City, town, or county) (State) <u>Baltimore</u>			
DATE REC'D BY LOCAL REG. <u>12-8-55</u>				24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1435

1732

STATE OF NEW YORK

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of attending physician: _____

11. Signature of medical examiner: _____

12. Signature of registrar: _____

13. Date of filing: 10/1/22

14. Signature of registrar: [Signature]

11786

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Sykesville</u>	LENGTH OF STAY (in this place) <u>22 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Walter E Chenoweth</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Dec. 23, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>12-22-1902</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>General</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Harry Chenoweth</u>		14. MOTHER'S MAIDEN NAME: <u>Rosanna Harkschneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>220-05-2846</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Martha Hart, 3706 Woodlawn Ave. Balt. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		30 hrs	
ANTECEDENT CAUSE (S) (B) <u>arteriosclerotic cardiovascular disease with hypertension</u>		15 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1941</u> , to <u>23 Dec., 1955</u> , that I last saw the deceased alive on <u>23 Dec., 1955</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. L. Lawrence</u>		DATE SIGNED <u>23 Dec. 1955</u>	
M. D. <u>Sykesville P.O., Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>12-27-1955</u>	
NAME OF CEMETERY OR CREMATORY: <u>Parkwood</u>		LOCATION (City, town, or county) (State): <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>Dec 24 1955</u>		24. FUNERAL DIRECTOR ADDRESS: <u>Robert R. Hurwitz, 4111 Birch Run, Home Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

11737

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>3Y, 2M, 6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>IDA</u> <u>BELLE</u> <u>DEAL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>14</u> <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4/9/82</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY NO. <u>1-55-104</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Thrombophlebitis, right leg</u>						<u>2 weeks</u>	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</u>						<u>4 years</u>	
19a. DATE OF OPERATION <u>12/13</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>12/13</u> <u>55</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/13</u> , 19 <u>55</u> , to <u>12/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Waldemar H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombed + stored</u>		DATE THEREOF <u>12/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Univ of Md. Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>C. Harry Sherris</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>DEC 19 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11781

11738

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>since 11-16-23</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS <u>409 N. Carrollton Avenue</u>					
3. NAME OF DECEASED (First) (Middle) (Last) <u>Victor W. DIXON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 6 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>January 2, 1882</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bottle-Cap Mfg.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>James Dixon</u>				14. MOTHER'S MAIDEN NAME <u>Bettie F. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic myocarditis and myocardial degeneration</u>						<u>more than 20 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Schizophrenic reaction, hebephrenic type</u>						<u>more than 30 yrs.</u>	
19a. DATE OF OPERATION <u>Dec. 5</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office <u>drug</u> , etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 1st, 1947</u> , to <u>Dec. 5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 5</u> , 19 <u>55</u> , and that death occurred at <u>7:05 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M. D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/9/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 9 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Keays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto.</u>		ADDRESS <u>Md.</u>	

DEATH CERTIFICATE

Form 10-1-55

UNITED STATES DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

Name of Deceased		Date of Birth		Sex	
Age		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Report		Date of Registration		Date of Filing	

BUREAU V. S.

DEC 9 1955

RECEIVED

RECEIVED

11789

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Sandwich</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
X TOWN <u>Sykesville, Maryland</u>	<u>5 1/2, 2 1/2 mo.</u>	<u>Westernport, Maryland</u>	<u>11 X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>15 Springfield State Hospital</u>		<u>R.F.D. # 1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Lula Frances Duckworth</u>		<u>12 28 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>10-25-1891</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>64 yrs.</u>		<u>Virginia</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Owen Derflinger</u>		<u>Ynk -</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Ynk</u>		<u>Ynk</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Hospital records</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
305X IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>		30 min.	
ANTECEDENT CAUSE (S) (B) <u>Alzheimer's Disease</u>		7 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-28-1950</u> , to <u>12-28-55</u> , that I last saw the deceased alive on <u>12-28-1955</u> , and that death occurred at <u>10:40 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ilse Kamm, M.D.</u>		DATE SIGNED <u>12-29-55</u>	
ADDRESS <u>M.D. Springfield Sykesville, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Westernport</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>Dec. 29, 1955</u>		<u>R. G. Boal - Westernport, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 2 1966
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11783

11790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>26 years +</u>		OR TOWN <u>Baltimore City</u>		OR TOWN <u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Herman</u> (Middle) <u>Eckmeyer</u> (Last)				(Month) <u>12</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed not known</u>	8. DATE OF BIRTH	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>not known</u>	
13. FATHER'S NAME <u>not known</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>715X Septicemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Decubitus ulcer</u>				<u>weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>904-7</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General paresis</u> <u>Fracture of neck of left femur</u>				<u>26 years + 3 mo +</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <u>Hospital ward 6</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Hospital ward 6</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Aug - 15 - 55</u> M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? <u>knocked by a disturbed patient.</u>			
22. I hereby certify that I attended the deceased from <u>July 19, 1955</u> , to <u>12-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-2</u> , 19 <u>55</u> , and that death occurred at <u>3:44</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Walther H. J. J. J. J.</u>				ADDRESS (Street, city, town, state) <u>Springfield State Hospital</u>			
DATE SIGNED <u>12/3/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenview</u>		LOCATION (City, town, or county) <u>German</u>	
24. REC'D BY REGISTRAR <u>6</u>		REGISTRAR'S SIGNATURE <u>C. Harry Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. J. J.</u>		ADDRESS <u>123</u>	
DATE <u>6 1955</u>							

BUREAU

BUREAU V. S.

DEC 7 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11784

11769

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL OR end give nearest town) Westminster		LENGTH OF STAY (In this place) 12 years		CITY (If outside corporate limits, write RURAL and give nearest town) Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 54 1/2 Carroll Street				STREET ADDRESS (If rural give location) 54 1/2 Carroll Street			
3. NAME OF DECEASED (First) Florence (Middle) Sarah (Last) Fitze				4. DATE OF DEATH (Month) Dec. (Day) 1 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 12, 1873	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. John R. Hesson				14. MOTHER'S MAIDEN NAME Mary Harner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 		17. INFORMANT & ADDRESS Rachel Fitze Westminster, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) Acute Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 24 hours			
ANTECEDENT CAUSE(S) DUE TO (B) General Cerebro-Sclerosis				10 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) 		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/30/55 , 19 55 , to 12/1/55 , that I last saw the deceased alive on 12/1/55 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE William Barr M.D.				ADDRESS (Street, city, town, state) Westminster, Md. DATE SIGNED 12/2/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 3, 1955		NAME OF CEMETERY OR CREMATORY Baust Cemetery		LOCATION (City, town, or county) (State) Tyrone, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harold Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	

200100100100

RECEIVED
JAN 10 1955
U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
BUREAU OF VITAL STATISTICS
WASHINGTON, D.C. 20001

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED John T. Brown		2. PLACE OF DEATH Baltimore, Maryland	
3. SEX Male		4. AGE 68	
5. DATE OF DEATH Dec 12, 1954		6. TIME OF DEATH 10:00 AM	
7. PLACE OF BIRTH Baltimore, Maryland		8. OCCUPATION Retired	
9. MARITAL STATUS Married		10. CAUSE OF DEATH Heart Disease	
11. SIGNATURE OF DECEASED John T. Brown		12. SIGNATURE OF WITNESSES Mary T. Brown	
13. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		14. SIGNATURE OF CORONER John D. Jones	
15. SIGNATURE OF REGISTRAR John D. Jones		16. SIGNATURE OF CLERK John D. Jones	

BUREAU V. 2

DEC 6 1955

RECEIVED

11791

CERTIFICATE OF DEATH

Reg. Dist. No. 11785

1. PLACE OF DEATH:

COUNTY

Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN

Woodbine

LENGTH OF STAY
(in this place)

4 years

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Waitzel Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md

COUNTY

HANOVER

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

HANOVER

13X-2

STREET
ADDRESS

R. F. D.

(If rural give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

SARAH A. FLOHR

4. DATE (Month)

(Day)

(Year)

OF
DEATH:

Dec

16

1955

5. SEX:

Female

6. COLOR OR
RACE:

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

Married

8. DATE OF BIRTH:

5/19/1876

9. AGE last birthday

79

yrs.

IF UNDER 1 YEAR
Months

Days

IF UNDER 24 HRS.
Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

Domestic

10B. KIND OF BUSINESS
OR INDUSTRY:

Maryland

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

Joseph Massey

14. MOTHER'S MAIDEN NAME:

Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

9

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

John B. Flohr, 15 Ingruder Ave,
Catonsville, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

INTERVAL BETWEEN
ONSET AND DEATH

7 years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1955, to Dec., 1955, that I last saw the deceased

alive on December 5, 1955, and that death occurred at 2:05 P.M., from the causes and on the date stated above.

SIGNATURE

W.B. Culwell

M. D.

ADDRESS

Int. City, Md.

DATE SIGNED

12/16/55

23. BURIAL, CREMATION,
REMOVAL, (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DEC 21 1955

Edna Hewitt

Mrs. Webb & Son

28

MARGIN RESERVED FOR BINDING

RECEIVED

DEC 21 1955

BUREAU V. S.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11792

CERTIFICATE OF DEATH

11786

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>4Y, 4M, 21 days</u>		OR TOWN <u>Rockville</u>		<u>15-26-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROSA</u>		(Middle) <u>ALICE</u>		(Last) <u>GROSHON</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>6/8/79</u>	
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Louis Craver</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ramsburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1. IMMEDIATE CAUSE (A) <u>420.0 Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic brain syndrome associated with senile brain disease, senile Parkinsonism</u>						<u>6 years</u>	
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4</u> , 19 <u>55</u> , to <u>12/12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/11</u> , 19 <u>55</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walker H. Tompkins, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC. 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>LAYTONSVILLE, CEMT</u>		LOCATION (City, town, or county) (State) <u>LAYTONSVILLE, MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Ware</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber, Laytonville Md</u>		ADDRESS	
DATE <u>DEC. 15, 1955</u>							

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

BUREAU V. S.

DEC 16 1955

RECEIVED

DEC 16 1955

11793

CERTIFICATE OF DEATH

11787

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural- Sykesville</u>		<u>27Y 2M 28 D</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3700 East Pratt Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u>		(Middle) <u>Martha</u>		(Last) <u>GROSS</u>		(Month) <u>12</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>8/1/93</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hrs. <u>55</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u> <u>USA</u>	
13. FATHER'S NAME <u>Robert Gross</u>				14. MOTHER'S MAIDEN NAME <u>Belle Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cerebral arteriosclerosis</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized arteriosclerosis</u>						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Epilepsy with mental deficiency</u>						years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/4</u> , 19 <u>55</u> , to <u>12/5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>55</u> , and that death occurred at <u>1:45A</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Dec. 8/55</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) <u>Eastern Blvd.</u>		(State)	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>C. Harry Marx</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		ADDRESS <u>Essex</u>			
DATE <u>DEC 8 1955</u>							

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

FILE NO.

DEATH NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

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EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

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RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

BUREAU VI. 1

8 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11788

11794 **CERTIFICATE OF DEATH**Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>9 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cumberland</u>		<u>0102-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15</u> <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>801 Bedford Street</u> ✓			
3. NAME OF DECEASED (Type or Print) <u>SHANNON</u> <u>AMBROSE</u> <u>HARDMAN</u>				4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-8-64</u>	9. AGE last birthday <u>91</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Agent</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unk -</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi Hardman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>			16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Terminal pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>few days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive heart disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile psychosis, simple deterioration.</u>						12 yr. +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28</u> , 19 <u>55</u> , to <u>12-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-11</u> , 19 <u>55</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>A. Lubizka</u>				ADDRESS (Street, city, town, state) <u>M.D. Springfield State Hosp. Sykesville</u>		DATE SIGNED <u>12-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-14-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>		LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR <u>slm</u>		REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Allen Inc.</u>		ADDRESS <u>Cumberland, Md.</u>	
DATE <u>12-12-55</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF SHERIFF'S DEPUTY

18. SIGNATURE OF SHERIFF'S CLERK

19. SIGNATURE OF SHERIFF'S DEPUTY CLERK

20. SIGNATURE OF SHERIFF'S DEPUTY CLERK

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BUREAU V. S.

DEC 15 1955

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DEC 15 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11795 **CERTIFICATE OF DEATH**

11789

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland COUNTY Carroll		CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster		CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster	
CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster		LENGTH OF STAY (in this place) 50 years		STREET ADDRESS (If rural give location) 19 Locust Street		STREET ADDRESS 19 Locust Street	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Augustus		(Middle) George		(Last) Humbert		Dec. 4 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH Oct. 24, 1869	9. AGE last birthday 86 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Silver Run, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Humbert				14. MOTHER'S MAIDEN NAME Sarah Gunder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no				16. SOCIAL SECURITY NO. 219-12-0084		17. INFORMANT & ADDRESS Clarence A. Humbert Westminster, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis						6+ yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 19 1953, to Dec 4 1955, that I last saw the deceased alive on Dec 3 1955, and that death occurred at 15:00 M, from the causes and on the date stated above.							
SIGNATURE Wesley Wilkins M.D.				DATE SIGNED 15 Kemper ave Westminster 12/5/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 6, 1955		NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		LOCATION (City, town, or county) (State) Silver Run, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Harold Miller		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers			
DATE 12-6-55				ADDRESS Westminster, Md.			

CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED (Print or Write)

JOHN EDWARD DUFFY

2. SEX

Male

3. AGE

30 years

4. PLACE OF BIRTH

St. Louis, Mo.

5. RACE

White

6. DATE OF DEATH

Dec. 3, 1955

7. TIME OF DEATH

10:00 AM

8. CAUSE OF DEATH

Myocardial Infarction

9. PLACE OF DEATH

Home

10. DATE OF BIRTH

Nov. 13, 1925

11. PLACE OF BIRTH

St. Louis, Mo.

12. OCCUPATION

Engineer

13. SIGNATURE OF PHYSICIAN

John E. Smith, M.D.

14. SIGNATURE OF REGISTRAR

John E. Smith, M.D.

15. SIGNATURE OF WITNESSES

John E. Smith, M.D.

16. DATE OF DEATH

Dec. 3, 1955

17. PLACE OF DEATH

Home

18. TIME OF DEATH

10:00 AM

19. CAUSE OF DEATH

Myocardial Infarction

20. PLACE OF DEATH

Home

21. DATE OF BIRTH

Nov. 13, 1925

22. PLACE OF BIRTH

St. Louis, Mo.

23. OCCUPATION

Engineer

BUREAU V. S.

DEC 8 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11790

11796

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Rural - Sykesville</u>		<u>4 months</u>		<u>Baltimore</u>		<u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15 Springfield State Hospital</u>				<u>920 N. Castle Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>FRANCES DALESICKY JECELIN</u>				<u>12 4 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Widowed</u>	<u>10/14/75</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>				<u>Czechoslovakia (Bohemia)</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						<u>years</u>	
(B) <u>Hypertensive cardiovascular disease</u>							
(C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>1 year/4</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/21</u> , 19 <u>55</u> , to <u>12/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>55</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-8-1955</u>		NAME OF CEMETERY OR CREMATORY <u>BAK HILL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
24. REC'D BY REGISTRAR <u>DEC 5 1955</u>		REGISTRAR'S SIGNATURE <u>E. Henry Kemp</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>FR. CVACH & SON</u>		ADDRESS <u>900 N. CHESTER ST.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11791

11797

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>MARYLAND</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		TOWN <u>3101.4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROZELLA</u>		(Middle) <u>E.</u>		(Last) <u>JOHNS</u>		(Year) <u>55</u>	
(Day) <u>12</u>		(Month) <u>25</u>		(Year) <u>19</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>6-30-1875</u>	
9. AGE last birthday <u>80</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Months <u>5</u>		Days <u>25</u>		Hours <u>-</u>		Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sch. teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard H. Johns</u>				14. MOTHER'S MAIDEN NAME <u>Eurith E. Leach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>6823 Thomas Blvd. Pittsburgh, PA.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE <u>450.0 Acute mesenteric Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>hours</u>			
ANTECEDENT CAUSE(S) DUE TO <u>arterio sclerosis</u>				years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Schizophrenia - Paranoid type</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-9</u> , 19 <u>36</u> , to <u>12-25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-25</u> , 19 <u>55</u> , and that death occurred at <u>6:05</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Gene R. Hoffman</u>				ADDRESS (Street, city, town, state) <u>Springfield State Hosp.</u>		DATE SIGNED <u>12-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Henry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart M. Brown</u>		ADDRESS <u>10820 North Ave</u>	
DATE <u>12-25-55</u>							

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

DEC 28 1955

BUREAU V. S.

RECEIVED

NOTED: This certificate is subject to the provisions of the Maryland Health and Safety Code, Chapter 10, and the regulations of the State Department of Health. It is to be filled out by the attending physician or other qualified person, and is to be filed in the office of the State Department of Health, Baltimore, Maryland.

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11792

11798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick Co.</u> <u>121</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>7 months 25 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frederick</u>		<u>10-11-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital.</u>				STREET ADDRESS <u>36 Franklin St.</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u>		(Middle) <u>Elizabeth</u>		(Last) <u>Kemp</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-23-1893</u>	9. AGE last birthday <u>62</u> yrs.	10. IF UNDER 1 YEAR Months <u>12</u> Days <u>30</u>	11. IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward William Peddicord</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wolfe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Mrs Eleanor Sheckles</u> <u>36 Franklin St. Frederick, Md. (daughter)</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Hypertensive cardio-vascular disease</u>						<u>years</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>years</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>C.B.S. associated with circulatory disturbance</u>						<u>two years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>other than cerebral arteriosclerosis with psychotic reaction</u>						<u>reaction</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-5</u>, 19<u>55</u>, to <u>12-30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-30</u>, 19<u>55</u>, and that death occurred at <u>2.15</u> a.m. from the causes and on the date stated above.							
SIGNATURE <u>Walker H. Sommerfeldt</u>				ADDRESS (Street, city, town, state) <u>M.D. Springfield State Hospital</u>		DATE SIGNED <u>12-30-1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) <u>Frederick Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u>		ADDRESS <u>Frederick Md.</u>	
DATE <u>Dec. 31, 1955</u>							

11111

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

CERTIFICATE OF DEATH

11938

Reg. Dist. No.

1. PLACE OF DEATH

2. DECEASED'S NAME (Last, first, middle)
3. SEX
4. AGE
5. DATE OF BIRTH
6. PLACE OF BIRTH
7. OCCUPATION
8. MARITAL STATUS
9. COLOR
10. RACE
11. RELIGION
12. EDUCATION
13. SERVICE
14. CAUSE OF DEATH
15. MANNER OF DEATH
16. SIGNATURE OF PHYSICIAN
17. SIGNATURE OF WITNESSES
18. SIGNATURE OF REGISTRAR
19. SIGNATURE OF CLERK
20. SIGNATURE OF JUDGE
21. SIGNATURE OF SHERIFF
22. SIGNATURE OF CORONER
23. SIGNATURE OF DISTRICT ATTORNEY
24. SIGNATURE OF COUNTY CLERK
25. SIGNATURE OF TOWNSHIP CLERK
26. SIGNATURE OF VILLAGE CLERK
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BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11793

11770

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Westminster</u>		<u>3 months</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>48 Longwell Ave.</u>				STREET ADDRESS (If rural give location) <u>1216 N. Calvert St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SALLIE ELIZABETH LANE</u>				<u>Dec. 10 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F.</u>	<u>W.</u>	<u>Married</u>	<u>Aug. 15, 1877</u>	<u>78</u> yrs.	Months	Days	Hours
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>U.S. - Md.</u>		<u>U.S. - G.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alexander J. Bowen</u>				<u>Betty Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Essie D. Schaffer, Westminster</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Myocardial degeneration</u>				<u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1, 1955</u>, to <u>Dec 10, 1955</u> that I last saw the deceased alive on <u>Dec 9, 1955</u>, and that death occurred at <u>3:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>E. Reese Wilkens</u>				<u>Westminster Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 14, 55</u>		<u>Baldwin Memorial Cem. Millersville, Md.</u>		<u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-11-55</u>		<u>Harriet Miller</u>		<u>Wm. Cook Funeral Home Baltimore Md.</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11794

11799

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
CITY OR TOWN <u>Manchester</u>		LENGTH OF STAY (in this place) <u>15-9-10</u>		STREET ADDRESS (If rural give location) <u>✓</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>							
3. NAME OF DECEASED (First) (Middle) (Last) <u>ANNA - MAE - LEISTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 30 19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 21-1930</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stuk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Koernok</u>				14. MOTHER'S MAIDEN NAME <u>Sadie M Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-26-8878</u>		17. INFORMANT & ADDRESS <u>Harold A Linter - Manchester Md</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Hemorrhage</u>						<u>5 minutes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>September 19 50</u>, to <u>December 30, 1955</u>, that I last saw the deceased alive on <u>12-29</u>, 19 <u>55</u>, and that death occurred at <u>1:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>W. H. Howard</u>		M.D.		ADDRESS (Street, city, town, state) <u>Manchester, Md.</u>		DATE SIGNED <u>12-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Snyderburg</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. W. R. Denner</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton - Hampstead Md</u>		ADDRESS	
DATE <u>Dec. 31-55</u>							

BUREAU V. S.

JAN 4 1951

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11800

CERTIFICATE OF DEATH

11795

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Maryland		COUNTY Carroll			
CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster		LENGTH OF STAY (in this place) life		CITY (If outside corporate limits, write RURAL and give nearest town) rural Westminster			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R 4 Gorsuch Road		STREET ADDRESS (if rural give location) R 4 Gorsuch Road					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Elizabeth (Middle) Keziah (Last) Leister				(Month) Dec. (Day) 15 (Year) 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Feb. 18, 1885	9. AGE last birthday 70 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Aaron Shaffer				14. MOTHER'S MAIDEN NAME Mary Bankert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS Howard J. Leister Westminster, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) Generalized Arterio Sclerosis						year	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____							
STATING UNDERLYING CAUSE LAST, DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1950, to 12/15, 1955, that I last saw the deceased alive on 12-15, 1955, and that death occurred at 3:45 P.M. from the causes and on the date stated above.							
SIGNATURE <i>James J. Shorob</i>				ADDRESS (Street, city, town, state) <i>Westminster Md</i>		DATE SIGNED <i>12/16/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Dec. 19, 1955		NAME OF CEMETERY OR CREMATORY Krider's Cemetery		LOCATION (City, town, or county) nr. Westminster, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Hanno Muller</i>		25. FUNERAL DIRECTOR'S SIGNATURE John R. Byers		ADDRESS Westminster, Md.	

CERTIFICATE OF DEATH

Page One

1. Name of deceased: **JOHN J. BROWN**

2. Date of birth: **1895**

3. Sex: **Male**

4. Race: **White**

5. Marital status: **Married**

6. Usual residence: **1234 Main St., Baltimore, Md.**

7. Date of death: **Dec 21, 1953**

8. Time of death: **10:30 AM**

9. Place of death: **Home**

10. Cause of death: **Heart Disease**

11. Immediate cause: **Myocardial Infarction**

12. Underlying cause: **Coronary Artery Disease**

13. Manner of death: **Natural**

14. Signature of physician: **Dr. J. A. Smith**

15. Signature of registrar: **John Doe**

16. Date of registration: **Dec 22, 1953**

17. Place of registration: **Baltimore, Md.**

18. Name of hospital: **St. Mary's Hospital**

19. Name of attending physician: **Dr. J. A. Smith**

20. Name of medical examiner: **Dr. J. A. Smith**

21. Name of coroner: **Dr. J. A. Smith**

22. Name of jury: **Dr. J. A. Smith**

23. Name of witness: **Dr. J. A. Smith**

24. Name of witness: **Dr. J. A. Smith**

25. Name of witness: **Dr. J. A. Smith**

26. Name of witness: **Dr. J. A. Smith**

27. Name of witness: **Dr. J. A. Smith**

28. Name of witness: **Dr. J. A. Smith**

29. Name of witness: **Dr. J. A. Smith**

30. Name of witness: **Dr. J. A. Smith**

31. Name of witness: **Dr. J. A. Smith**

32. Name of witness: **Dr. J. A. Smith**

33. Name of witness: **Dr. J. A. Smith**

34. Name of witness: **Dr. J. A. Smith**

35. Name of witness: **Dr. J. A. Smith**

36. Name of witness: **Dr. J. A. Smith**

37. Name of witness: **Dr. J. A. Smith**

38. Name of witness: **Dr. J. A. Smith**

BUREAU V. S.

DEC 21 1953

RECEIVED

1215101042

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MB/slm

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11801

CERTIFICATE OF DEATH

11796

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville, Maryland</u>		<u>1 yr. 8 mo. 26 days</u>		TOWN <u>Cambridge</u>		<u>09/13/52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>301 Peach Blossom Street</u> ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>THELMA</u>				<u>LEWIS</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>5-28-13</u>	
9. AGE last birthday <u>42 yrs.</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Blanche Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Heart Fibrillation</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Tuberculosis</u>						<u>Approx. 2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with convulsive disorder, psychotic reaction.</u>						<u>30 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-16</u> , 19 <u>54</u> , to <u>12-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-12</u> , 19 <u>55</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12-12-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Kearns Cemetery</u>		LOCATION (City, town, or county) <u>Kearns Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Henry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens ave</u>	
DATE <u>Dec 12/1955</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11797

11802

CERTIFICATE OF DEATH

Item 8, Film 190 12-27-55 et

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll Co.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural, Westminster</u>		<u>7 yrs.</u>		TOWN <u>Rural, Westminster</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Westminster RD #5</u>				<u>Liberty St. East</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SARAH JANE MANGER</u>				<u>DEC. 14 19 55</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 24, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Manger Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE				<u>with fibrillar</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>arteriosclerotic heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				(B) <u>arteriosclerosis</u>			
STATING UNDERLYING CAUSE LAST, DUE TO				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 8 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13, 1955</u> to <u>Dec 14, 1955</u> that I last saw the deceased alive on <u>Dec 13, 1955</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Antonie Wilberys</u> M. D.				ADDRESS (Street, city, town, State) <u>Westminster, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Carroll Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Muller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>12-15-55</u>							

DEC 10 1955

RECEIVED

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11798

CERTIFICATE OF DEATH

Reg. Dist. No. 74

11803

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Rural		3 yrs 2 Mo.		TOWN Baltimore		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.				STREET ADDRESS (If rural give location) 24 e. Lanvale St.			
3. NAME OF DECEASED (Type or Print) John T. Mc Auliffe				4. DATE OF DEATH (Month) 12 (Day) 23 (Year) 19 55			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH ? ? 18 74	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR (Month) (Day) (Year)		IF UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Donhue				14. MOTHER'S MAIDEN NAME Hanora Donhue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT & ADDRESS Records of Springfield Hospital			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
447X IMMEDIATE CAUSE (A) Cerebro-Vascular Accident						20 Minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Hypertensive						15 Yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 6 , 19 52 , to Dec. 23 , 19 55 , that I last saw the deceased alive on Dec. 23 , 19 55 , and that death occurred at 11 P.M. , from the causes and on the date stated above.							
SIGNATURE <i>Signerau Roddy Remyer</i>				ADDRESS (Street, city, town, state) <i>SVH</i>		DATE SIGNED <i>12-24-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-26-55</i>		NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		LOCATION (City, town, or county) <i>Bald. Md.</i> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>C. Harry Zuer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Mears</i>		ADDRESS <i>805 N. Calvert St.</i>	
DATE <i>12-24-55</i>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11799

11804

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>24 years</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2821 Chesterfield Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Anna</u>		(Middle) <u>Marie</u>		(Last) <u>Meisel</u>		<u>Dec. 9 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married W</u>	<u>9-18-1891</u>	<u>64</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Cigarette maker</u>		<u>unk</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Schoenholtz</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Fleishman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>unk</u>		<u>Hospital records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
025X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
ANTECEDENT CAUSE(S) DUE TO						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO						<u>Years</u>	
(C) <u>Psychosis with Cerebro-spinal syphilis</u>						<u>Years</u>	
19a. DATE OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b. MAJOR FINDINGS OF OPERATION							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-25</u> , 19 <u>31</u> , to <u>12-9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-9</u> , 1955, and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gertrude Sounefeldt M.D. Springfield State Hospital, Sykesville Md.</u>				DATE SIGNED <u>12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 12, 1955</u>		<u>Sacred Heart Cemetery</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>Dec 10, 1955</u>		<u>C. Henry Eden</u>		<u>Leonard J. Ruck, 5305 Harford Road #14</u>			

CERTIFICATE OF DEATH

1955

Reg. Dist. 1955

1. LEGAL RESIDENCE (HOME OF DECEASED)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. EDUCATION

12. BIRTH DATE

13. BIRTH PLACE

14. RACE

15. RELIGION

16. SOCIAL SECURITY NUMBER

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESSES

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF CORONER

22. SIGNATURE OF JURY

23. SIGNATURE OF DECEASED

24. SIGNATURE OF WITNESSES

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF PHYSICIAN

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF DECEASED

30. SIGNATURE OF WITNESSES

31. SIGNATURE OF REGISTRAR

32. SIGNATURE OF PHYSICIAN

33. SIGNATURE OF CORONER

34. SIGNATURE OF JURY

35. SIGNATURE OF DECEASED

36. SIGNATURE OF WITNESSES

37. SIGNATURE OF REGISTRAR

38. SIGNATURE OF PHYSICIAN

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF DECEASED

42. SIGNATURE OF WITNESSES

43. SIGNATURE OF REGISTRAR

BUREAU V. 8

DEC 15 1955

RECEIVED

RECEIVED

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy is to be sent to the local health officer of the jurisdiction in which the death occurred. The certificate is to be filled out in duplicate, and the original is to be retained by the physician or coroner who has examined the body of the deceased.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11800

11805

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>33yr. 6mo. 25days</u>		TOWN <u>Mt. Rainer</u>		<u>1616-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3210 upshur st</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>AMANDA</u> (First) <u>MILLER</u> (Middle) (Last)				<u>12</u> <u>19</u> <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>March 27, 1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Typist</u>					<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James W. Miller</u>				<u>Sally Blair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Unk.</u>					<u>Hospital records</u>		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Acute edema of lung</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						hrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						hrs.	
(C) <u>Arteriosclerotic Heart Disease</u>						yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dementia Praecox - hebephrenic type.</u>						33 yr. +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-19</u> , 19 <u>55</u> , to <u>12-19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>55</u> , and that death occurred at <u>8:30P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D. <u>Sykesville, Maryland</u>				DATE SIGNED <u>12-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>12/22/55</u>		<u>Park Heights Cem Co</u>		<u>Brunswick, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 23 1955</u>		<u>Victor E. Harris</u>		<u>F. Gasch's Sons Sykesville Md</u>			

CERTIFICATE OF DEATH

Reg. No. 123

1. USUAL RESIDENT HOME OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF CLERK

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF JUDGE

RECEIVED

RECEIVED
DEC 23 1955
BUREAU A. 8

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11801

11806

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>7 days</u>		OR TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3745 Beech Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SAMUEL</u> (Middle) <u>HULETT</u> (Last) <u>PENNINGTON</u>				(Month) <u>12</u> (Day) <u>27</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>10/15/96</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee R. Pennington</u>				14. MOTHER'S MAIDEN NAME <u>Lareine M. Hulett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>536-10-3993</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Irreversible Shock</u>						<u>hours</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>perforated gastric ulcer</u>						<u>1 day</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic brain syndrome with psychotic reaction due to cerebral arteriosclerosis</u>						<u>1 month</u>	
19a. DATE OF OPERATION <u>12/26/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Perforated gastric ulcer and bile peritonitis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>12/26/55</u> , 19 <u> </u> , to <u>12/27/</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>55</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William R. Adams, Jr.</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>12/29/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 28 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u> ADDRESS <u>Ellsworth Armacost - 4600 Liberty Hghts. Ave.</u>			

CERTIFICATE OF DEATH

1. Name of deceased

2. Place of birth

3. Date of birth

4. Sex

5. Race

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of registrar

12. Date of filing

BUREAU V. S.

DEC 28 1935

RECEIVED

20073044254

11807

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Carroll</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Carroll</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Winfield</i>	LENGTH OF STAY (in this place) <i>Life</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Winfield</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <i>Edgar</i> (Middle) <i>E.</i> (Last) <i>Pickett</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Dec. 14 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>Aug. 2, 1882</i>
9. AGE last birthday: <i>73</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Broom maker</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Broom</i>	
11. BIRTHPLACE (State or foreign country): <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>Wm. H. Pickett</i>		14. MOTHER'S MAIDEN NAME: <i>Anna Haines</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT & ADDRESS: <i>Mr. Bertha Pickett - Westminster Md.</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Generalized carcinomatosis</i>		<i>3+ months</i>	
ANTECEDENT CAUSE (S) (B) <i>adenocarcinoma of rectum</i>		<i>1+ years.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Adenocarcinoma of rectum</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1954</i> , 19..., to <i>14 Dec., 1955</i> , that I last saw the deceased alive on <i>12 Dec., 1955</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.			
SIGNATURE <i>H. Lawrence</i>		DATE SIGNED <i>14 Dec. 1955</i>	
M. D. <i>Dykesville - md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-16-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Ebenezzer</i>		LOCATION (City, town, or county) (State) <i>Winfield, Carroll, md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Dec. 15, 1955</i>		REGISTRAR'S SIGNATURE <i>E. M. Farrow</i>	
24. FUNERAL DIRECTOR <i>Arthur H. Haight - Dykesville, md.</i>		ADDRESS	

RECEIVED

DEC 28 1955

BUREAU V. S.

11803

11808 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Carroll	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City
CITY OR TOWN Sykesville, Maryland	LENGTH OF STAY (in this place) 3yrs. 9mos.	STREET ADDRESS (If rural give location) 4114 Fernhill Ave.	
3. NAME OF DECEASED (First) (Middle) (Last) Emma Louise Pindell		4. DATE OF DEATH (Month) (Day) (Year) 12 23 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-22-1875
9. AGE last birthday 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Ogdensburg, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Farley		14. MOTHER'S MAIDEN NAME Fanny Houniel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk.		16. SOCIAL SECURITY NO. 44-38-10000	
17. INFORMANT & ADDRESS Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) 490x Lobar pneumonia		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Chronic myocarditis		10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Gen'l. arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. 11:00		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-27-1952 , to 12-21-1955 , that I last saw the deceased alive on 12-21-1955 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
SIGNATURE M.D. Walter M.D.		ADDRESS (Street, city, town, state) M.D. Springfield State Hosp. Sykesville, Md.	
DATE SIGNED 12-23-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. DATE THEREOF 12-27-55	
NAME OF CEMETERY OR CREMATORY London Park		LOCATION (City, town, or county) (State) Baltimore Md.	
25. REC'D BY REGISTRAR C. H. H. H.		26. REGISTRAR'S SIGNATURE C. H. H. H.	
27. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook & Son		28. ADDRESS 1217 St. Paul St. Balt. Md.	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

11903

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

11903

DATE OF DEATH

1. NAME OF DECEASED

2. SEX OF DECEASED

3. AGE OF DECEASED
4. PLACE OF BIRTH
5. OCCUPATION

6. CAUSE OF DEATH
7. MANNER OF DEATH

8. DATE OF DEATH
9. TIME OF DEATH

10. PLACE OF DEATH
11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JURY

21. SIGNATURE OF JURY

22. SIGNATURE OF JURY

23. SIGNATURE OF JURY

24. SIGNATURE OF JURY

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36. SIGNATURE OF JURY

37. SIGNATURE OF JURY

38. SIGNATURE OF JURY

39. SIGNATURE OF JURY

40. SIGNATURE OF JURY

41. SIGNATURE OF JURY

BUREAU V. B.

DEC 28 1955

RECEIVED

RECEIVED
BALTIMORE, MD
DEC 28 1955
BUREAU V. B.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11809

CERTIFICATE OF DEATH

11804

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>3 mos. 29 days</u>		TOWN <u>Pasadena</u>		<u>13x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 5 -- Box 205</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Evelyn</u> (Middle) <u>Ridgely</u> (Last)				(Month) <u>12</u> (Day) <u>14</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-17-1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u>	11. BIRTHPLACE (State or foreign country) <u>Pasadena, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Humphrey Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Riggs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>420</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Suddenly</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>D</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-12-</u> , 19 <u>55</u> , to <u>12-13-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-13-</u> , 19 <u>55</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. N. Mastin, M.D.</u>				ADDRESS (Street, city, town, state) <u>M. D. Springfield State Hosp., Sykesville, Md.</u>		DATE SIGNED <u>12-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		LOCATION (City, town, or county) (State) <u>Glenwood, Howard, Md.</u>	
24. REC'D BY REGISTRAR <u>Dec. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	

11801

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

CERTIFICATE OF DEATH

11800

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

BUREAU V. S.

DEC 20 1975

RECEIVED

RECEIVED

RECEIVED
 DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND
 11800

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11806

11810

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>P. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Henryton</u>		<u>1 yr. 6 mos. 9 das.</u>		TOWN <u>Deanwood Park</u>		<u>16X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>1101 54th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joseph</u> (Middle) <u>Robinson</u> (Last)				(Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-2-1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greenwood, S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walter S. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Deceased</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Liver damage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary tuberculosis, far advanced</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 7, 1954</u> , to <u>Dec. 16, 1955</u> , that I last saw the deceased alive on <u>Dec. 16, 1955</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>T. F. Heslar</u>		M.D. <u>Henryton, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>12-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>12/17/55</u>		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
						<u>Washington D.C.</u>	
24. REC'D BY REGISTRAR DATE <u>12-16-55</u>		REGISTRAR'S SIGNATURE <u>Albert R. Summham</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u>		ADDRESS <u>467 N St. N.W. Wash, D.C.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form No. 10-1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESS

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF CORONER

21. SIGNATURE OF JURY

22. SIGNATURE OF JUDGE

23. SIGNATURE OF DISTRICT ATTORNEY

24. SIGNATURE OF STATE ATTORNEY

25. SIGNATURE OF ATTORNEY GENERAL

26. SIGNATURE OF SECRETARY OF STATE

27. SIGNATURE OF COMMISSIONER OF HEALTH

28. SIGNATURE OF DEPUTY COMMISSIONER

29. SIGNATURE OF ASSISTANT COMMISSIONER

30. SIGNATURE OF CHIEF CLERK

31. SIGNATURE OF CLERK

32. SIGNATURE OF RECEPTIONIST

33. SIGNATURE OF ATTENDANT

34. SIGNATURE OF NURSE

35. SIGNATURE OF DOCTOR

36. SIGNATURE OF PHARMACEUTICAL

37. SIGNATURE OF LABORATORY

38. SIGNATURE OF PATHOLOGIST

39. SIGNATURE OF RADIOLOGIST

40. SIGNATURE OF HISTOLOGIST

41. SIGNATURE OF CYTOLOGIST

42. SIGNATURE OF MICROSCOPIC

43. SIGNATURE OF BACTERIOLOGIST

44. SIGNATURE OF VIROLOGIST

45. SIGNATURE OF IMMUNOLOGIST

46. SIGNATURE OF EPIDEMIOLOGIST

47. SIGNATURE OF STATISTICIAN

48. SIGNATURE OF PUBLIC HEALTH

49. SIGNATURE OF COMMUNITY

50. SIGNATURE OF MEDICAL

51. SIGNATURE OF DENTAL

52. SIGNATURE OF OPTOMETRIC

53. SIGNATURE OF PODIATRIC

54. SIGNATURE OF CHIROPRACTOR

55. SIGNATURE OF NUTRITIONIST

56. SIGNATURE OF DIETETICIAN

57. SIGNATURE OF FOOD SERVICE

BUREAU V. S.

DEC 21 1955

RECEIVED

Handwritten signature and date: 12-21-55

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11771

CERTIFICATE OF DEATH

11807

Reg. Dist. No. 26

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>CARROLL</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>CARROLL</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WESTMINSTER</u>	LENGTH OF STAY (In this place) <u>62 YRS.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WESTMINSTER</u>	<u>27</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>43 E. MAIN</u>		STREET ADDRESS (If rural give location) <u>43 E. MAIN</u>	<u>1</u>
3. NAME OF DECEASED (Type or Print) <u>VOLA AGNES RUPPERT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 3 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 28 1893</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RICHARD ARNOLD</u>		14. MOTHER'S MAIDEN NAME <u>LAURA TANNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-1372</u>	
17. INFORMANT & ADDRESS <u>JOSEPH A. RUPPERT 43 E. MAIN WESTMINSTER MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
592X IMMEDIATE CAUSE (A) <u>Chronic Valvular Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1445</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertension & chronic</u>			
(C) <u>nephritis</u>		<u>10-15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u>, 19<u>40</u>, to <u>Dec 3</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Dec 3</u>, 19<u>55</u>, and that death occurred at <u>11:45 P.</u>M, from the causes and on the date stated above.			
SIGNATURE <u>William Speck</u>		ADDRESS (Street, city, town, state) <u>Westminster MD.</u>	
DATE SIGNED <u>12/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-7-1955</u>	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>	
REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		LOCATION (City, town, or county) (State) <u>Westminster MD.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>H. BANIKARD & SON</u>		ADDRESS <u>WESTMINSTER MD.</u>	

BUREAU V. S.

DEC 9 1965

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11808

11811

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County CARROLL CO.
 City or town GAMBER, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs
 Hospital, institution, or street address where death occurred: on
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County CARROLL
 City or town GAMBER, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

JOHN WILBERT L. SCHARFE

3. (b) Social Security Number

9

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
 6. (b) Name of husband or wife EMILY J. SCHARFE
 7. Birth date of deceased (mo., day, yr.) JUNE 9, 1886
 8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace MARYLAND.
 (Town, county, and state)
 10. Usual occupation RETIRED MACHINIST
 11. Industry or business BLACK & DECKER
 12. Name HERMAN SCHARFE
 13. Birthplace MARYLAND.
 14. Maiden name ALICE H. SIPPLE
 15. Birthplace MARYLAND

16. Informant EMILY J. SCHARFE
 Address GAMBER, MD.
 17. Burial Date thereof Dec. 26, 1955
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory PROVIDENCE
 Location GAMBER, MD.
 18. Funeral director Austin E. Donovan
 Address 3818 Roland Ave,
 19. Dec. 24 19 55
 (Date rec'd by registrar)

R.W.
 Registrar

MEDICAL CERTIFICATION

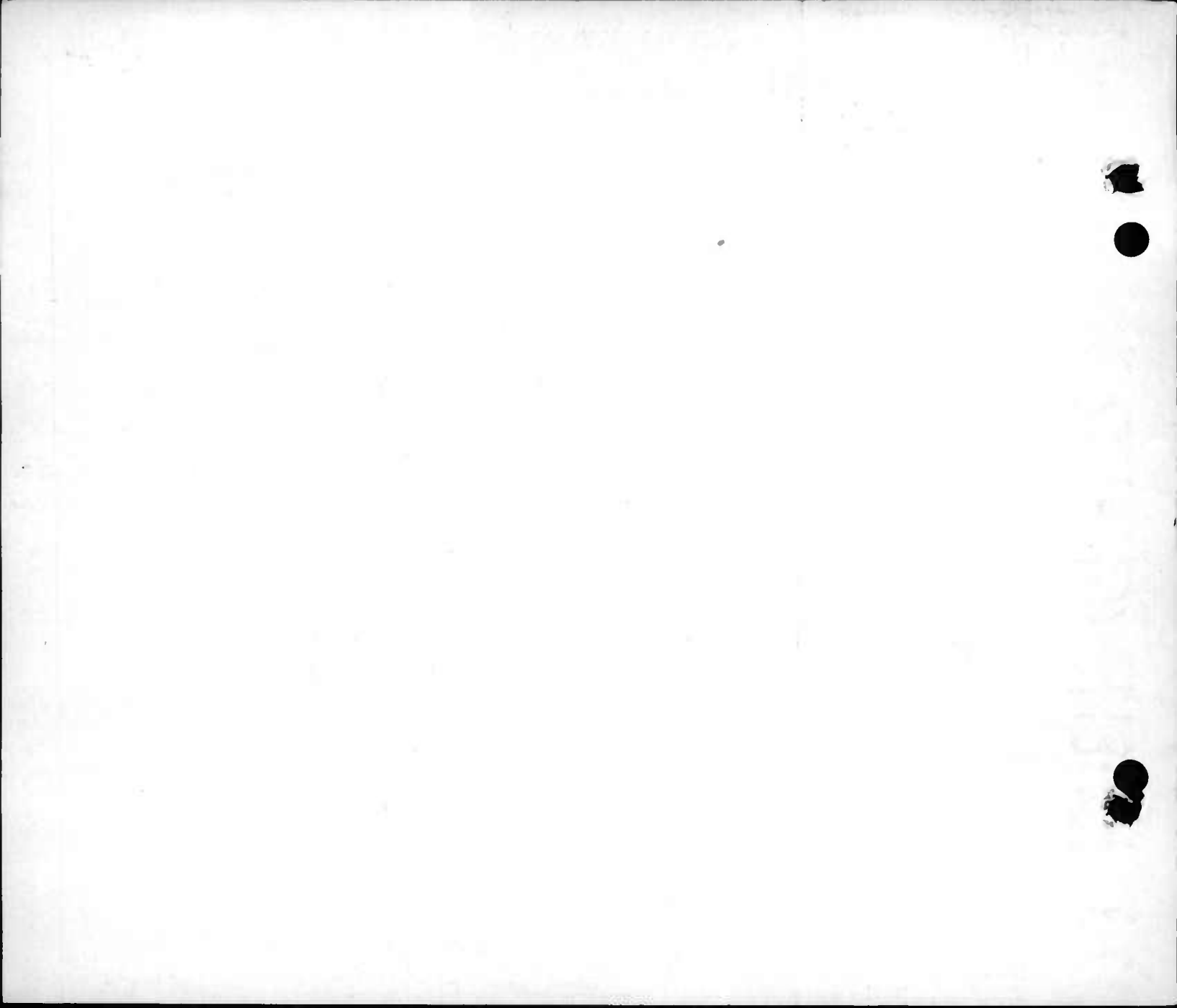
20. DATE OF DEATH DECEMBER 23, 1955 at 7:05 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1955 to 23 Dec 1955
 and that I last saw him alive on 23 Dec 55
 Immediate cause of death Cardiac arrest.
Bronchial pneumonia.
Asphyxia, arteriosclerotic heart
disease

DURATION 2 months
 Due to 430.0
 Due to
 Other conditions

0 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Howard E. Hall
 M. D. or other Superior, Ind
 Address Date signed 23 Dec 55



1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11809

11812

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		LENGTH OF STAY (In this place) <u>80 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. 6</u>				STREET ADDRESS (If rural give location) <u>R.D. 6</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FRANK ALBERT SCHERER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12-12-1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>6-2-1870</u>		9. AGE last birthday <u>85</u> yrs.	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>12</u> Months <u>12</u> Days <u>12</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>DANIEL SCHERER</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA WHITLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>ELLA Z. FAHINNEY, FREDERICK, MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal disease</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> to <u>Dec 12, 1955</u>, that I last saw the deceased alive on <u>Dec 12, 1955</u>, and that death occurred at <u>5:00 AM</u>, from the causes and on the date stated above.							
SIGNATURE <u>W. Glenn Perches</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster, Md.</u>			
DATE SIGNED <u>12-12-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-14-1955</u>		NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		LOCATION (City, town, or county) (State) <u>FREDERICK MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bankard</u>		ADDRESS <u>Don Westminster, Md.</u>	
DATE <u>12-16-55</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

NO. [illegible]
STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
BALTIMORE, MARYLAND

RECEIVED
DEC 18 1965
BUREAU V. S.

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11810

11813

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>10 mo</u>		TOWN <u>Baltimore City</u>		<u>3 vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2307 Aisquith St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James Thomas Schiller</u>				<u>Dec. 17 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>wid.</u>	8. DATE OF BIRTH <u>Nov. 1863</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>cigar store</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington Delaware, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Schiller</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dunbar</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>220-07-70124</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>generalized arteriosclerosis</u>						<u>more than 10 mo</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>psychosis with senile brain disease</u>						<u>more than 10 mo</u>	
19a. DATE OF OPERATION <u>8</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 2</u> , 19 <u>55</u> , to <u>Dec. 17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>55</u> , and that death occurred at <u>10:48</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>Dec. 18, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Overbrook</u>		LOCATION (City, town, or county) (State) <u>Brighton, N. J.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Henry Wier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Anderson</u>		ADDRESS <u>1000 N. Broadway</u>	
DATE <u>Dec. 18, 1955</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
1818
CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

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BUREAU V. S.

DEC 22 1935

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11814

CERTIFICATE OF DEATH

11811

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>5Y, 1M, 12 days</u>		TOWN <u>Baltimore</u>		<u>3Y 01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>301 South Monroe Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Albert George SEITLER</u>				<u>12 1 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>W</u>	<u>single</u>	<u>12/9/04</u>	<u>50</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Helper in shipping dept.</u>		<u>utilities</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Leo Seidler</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Cromwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or u.s.g.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unknown</u>				<u>Record, Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
154X IMMEDIATE CAUSE (A) <u>Carcinoma of rectum with metastases to liver</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						2 weeks	
<u>Colostomy performed</u>						5 years +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>11/15/55</u>		<u>Parent lesion in rectum; liver studded with CA</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/20</u> , 19 <u>55</u> , to <u>12/1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/1</u> , 19 <u>55</u> , and that death occurred at <u>8:10AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Springfield</u> M.D.				DATE SIGNED <u>12/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/6/55</u>		<u>Forest Hill</u>		<u>Germanville</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 6 1955</u>		<u>C. Harry Harris</u>		<u>J. J. Carey</u>		<u>1000</u>	

CERTIFICATE OF DEATH

11814

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF MINISTERS		20. SIGNATURE OF MUSICIANS		21. SIGNATURE OF GUESTS	
22. SIGNATURE OF OTHERS		23. SIGNATURE OF OTHERS		24. SIGNATURE OF OTHERS	
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SMOOTHED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE BURIAL OFFICIAL TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE FUNERAL HOME TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE CHURCH TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE CEMETERY TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE MINISTERS TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE MUSICIANS TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE GUESTS TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR. IT IS THE DUTY OF THE OTHERS TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR.

BUREAU V. S.

DEC 7 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11815

CERTIFICATE OF DEATH

12556

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		STATE <u>M.D.</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HAMPSTEAD</u>		LENGTH OF STAY (in this place)		TOWN <u>RURAL HAMPSTEAD</u>		STREET ADDRESS (If rural give location) <u>R.D. 1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.D. 1</u>				STREET ADDRESS <u>R.D. 1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MURRAY RITTER SLAGLE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 28 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>7-7-1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>P.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MARTIN L. SLAGLE</u>				14. MOTHER'S MAIDEN NAME <u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-20-18-1593</u>		17. INFORMANT & ADDRESS <u>Martin L. Slogle Hampstead, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arterio-sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Old Coronary Thrombosis</u>				1944			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1944</u> to <u>Dec 20 1955</u> , that I last saw the deceased alive on <u>Dec 20 1955</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. C. Porter</u>				ADDRESS (Street, city, town, state) <u>Hampstead, Md.</u>		DATE SIGNED <u>12-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>12-31-1955</u>		NAME OF CEMETERY OR CREMATORY <u>KRIDERS GEM.</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Bankard</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>1-6-56</u>							

INDICATE

1
 This is a form for the purpose of indicating the results of the examination of the body of a deceased person. It is to be filled out by the medical examiner or the coroner, and the results of the examination are to be indicated by the appropriate initials or marks in the spaces provided. The form is to be filled out in duplicate, and the original is to be retained by the medical examiner or the coroner, and the duplicate is to be forwarded to the Bureau of the Department of Health, Baltimore, Maryland.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX
 (M) (F)

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF MEDICAL EXAMINER

9. SIGNATURE OF CORONER

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED

12. SIGNATURE OF MEDICAL EXAMINER

13. SIGNATURE OF CORONER

14. SIGNATURE OF WITNESS

15. SIGNATURE OF DECEASED

16. SIGNATURE OF MEDICAL EXAMINER

17. SIGNATURE OF CORONER

18. SIGNATURE OF WITNESS

19. SIGNATURE OF DECEASED

20. SIGNATURE OF MEDICAL EXAMINER

21. SIGNATURE OF CORONER

22. SIGNATURE OF WITNESS

23. SIGNATURE OF DECEASED

24. SIGNATURE OF MEDICAL EXAMINER

25. SIGNATURE OF CORONER

26. SIGNATURE OF WITNESS

BUREAU V. S.

JAN 9 1936

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11816

CERTIFICATE OF DEATH

11812

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u> MARYLAND				STATE <u>Maryland</u> COUNTY _____			
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN <u>Rural - Sykesville</u> since <u>7-13-55</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>19 E. Centre Street, Baltimore-2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Washington - SPANGLE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>12 3 1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>July 9, 1882</u>		9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>printing</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>James Spangle</u>				14. MOTHER'S MAIDEN NAME <u>unknown to us</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
260X IMMEDIATE CAUSE (A) <u>CEREBRAL ARTERIO SCLEROSIS ENCEPHAL</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>1. HYPERTENSION DUE TO ARTERIO SCLEROSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>R. HEMIPLEGIA.</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH ARTERIO SCLEROSIS</u>						<u>years</u> <u>years</u>	
19a. DATE OF OPERATION ____		19b. MAJOR FINDINGS OF OPERATION ____					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ____		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) ____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) ____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ____			
22. I hereby certify that I attended the deceased from Nov. 28th, 1955, to December 3, 1955, that I last saw the deceased alive on 12-3, 1955, and that death occurred at 11:24 A.M. from the causes and on the date stated above.							
SIGNATURE <u>L. Radkyrewicz</u>		M.D. ____		ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>		DATE THEREOF <u>12/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>Coalport</u>		LOCATION (City, town, or county) (State) <u>Coalport, Pennsylvania</u>	
24. REC'D BY REGISTRAR <u>DEC 6 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm Book Inc 1217 St. Paul Street</u>			

CERTIFICATE OF DEATH

Form No. 10

1. USUAL RESIDENCE PRIOR TO DEATH

2. PLACE OF DEATH

3. NAME OF DECEASED
 4. SEX
 5. AGE
 6. DATE OF BIRTH
 7. DATE OF DEATH
 8. TIME OF DEATH
 9. PLACE OF DEATH
 10. CAUSE OF DEATH
 11. MANNER OF DEATH
 12. SIGNATURE OF PHYSICIAN
 13. SIGNATURE OF WITNESSES
 14. SIGNATURE OF DECEASED
 15. SIGNATURE OF REGISTRAR

16. NAME OF PHYSICIAN
 17. NAME OF WITNESSES
 18. NAME OF DECEASED
 19. NAME OF REGISTRAR

20. NAME OF PHYSICIAN
 21. NAME OF WITNESSES
 22. NAME OF DECEASED
 23. NAME OF REGISTRAR

24. NAME OF PHYSICIAN
 25. NAME OF WITNESSES
 26. NAME OF DECEASED
 27. NAME OF REGISTRAR

28. NAME OF PHYSICIAN
 29. NAME OF WITNESSES
 30. NAME OF DECEASED
 31. NAME OF REGISTRAR

32. NAME OF PHYSICIAN
 33. NAME OF WITNESSES
 34. NAME OF DECEASED
 35. NAME OF REGISTRAR

BUREAU V. S.

DEC 7 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11813

11817 CERTIFICATE OF DEATH

Items 10a, 11, 13, 14 Film G190 12-23-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MIDDLESEX		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Rural - Sykesville</u>		<u>11 days</u>		TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>421 West 24th Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>CHARLES</u> (Middle) <u>MILTON</u> (Last) <u>SPRING</u>				(Month) <u>12/</u> (Day) <u>13</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>		<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>several years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/2</u> , 19 <u>55</u> , to <u>12/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>55</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Sonnenfeldt</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/16/55</u>		<u>Baltimore</u>		<u>E. North Ave.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 15 1955</u>		<u>C. Harry Kees</u>		<u>Paul E. Schenck</u>		<u>3615-17 Schenck</u>	

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RECEIVED

DEC 16 1955

BUREAU V. S.

1955 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE 15

1955

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF NEXT OF KIN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF DISTRICT ATTORNEY

19. SIGNATURE OF COUNTY CLERK

20. SIGNATURE OF TOWN CLERK

21. SIGNATURE OF VOTING CLERK

22. SIGNATURE OF POLLING CLERK

23. SIGNATURE OF BALLOT CLERK

24. SIGNATURE OF CANVASSER

25. SIGNATURE OF CHIEF CLERK

26. SIGNATURE OF ASSISTANT CLERK

27. SIGNATURE OF DEPUTY CLERK

28. SIGNATURE OF CLERK IN CHARGE

29. SIGNATURE OF CLERK AT LARGE

30. SIGNATURE OF CLERK OF THE COURT

31. SIGNATURE OF CLERK OF THE HOUSE

32. SIGNATURE OF CLERK OF THE SENATE

33. SIGNATURE OF CLERK OF THE JUDICIAL BRANCH

34. SIGNATURE OF CLERK OF THE EXECUTIVE BRANCH

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120. SIGNATURE OF CLERK OF THE JUDICIAL BRANCH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

11814

11818

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. *70* *80*

1. PLACE OF DEATH- COUNTY <i>Carroll</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Uniontown Rural</i> TOWN <i>Uniontown Rural</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>on</i>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Carroll</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Uniontown Rural</i> TOWN <i>Uniontown Rural</i> STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>ELMER KEFAUVER STAMBAUGH</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Dec 12 1955</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>		8. DATE OF BIRTH <i>April 1-1914</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cambridge, Pub</i>		9. AGE last birthday <i>41</i> yrs.		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Joseph H Stambaugh</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Wilhide</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>217-12-1464</i>				17. INFORMANT <i>Elizabeth D Stambaugh Uniontown Rural</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <i>981X Gunshot wound of abdomen</i> Antecedent cause(s) <i>minutes</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>(c)</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <i>0</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				PLACE (Home, farm, factory, street, office bldg., etc.) <i>Home</i>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>12 12 55 10P</i> m.				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
				HOW DID INJURY OCCUR? <i>Shot with shot gun</i>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input type="checkbox"/> .							
SIGNATURE <i>James J. March</i> Deputy Medical Examiner <i>Wheaton Md</i>				DATE SIGNED <i>12/13/55</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Dec 15-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Lutheran</i>		LOCATION (City, town, or county) (State) <i>Uniontown Md</i>	
DATE REC'D BY LOCAL REG. <i>Dec 14/55</i>		REGISTRAR'S SIGNATURE <i>Ethel M. Mehning</i>		24. FUNERAL DIRECTOR <i>Ed Hartley & Sons, Union Bridge Md</i>		ADDRESS	

BUREAU V. S.

DEC 19 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11815

11819

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frizzleburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frizzleburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Margaret Savilla Stevenson</u>		4. DATE OF DEATH <u>Dec. 9, 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 13, 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus Utermahlen</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wantz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. s Louise Nygren, Frizzleburg, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
442X Immediate cause (a) <u>Acute cardiac dilatation</u>		<u>18 hrs</u>	
Antecedent cause(s) (b) <u>Cardio Renal Vascular disease</u>		<u>4 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Jan 1, 1951, to Dec 9, 1955, that I last saw the deceased alive on Dec 8, 1955, and that death occurred at 5:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Chas. R. Foote, M.D., Westminster, Md. ADDRESS Westminster, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Dec. 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>	LOCATION (City, town, or county) <u>Pleasant Valley, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>12/16</u>		REGISTRAR'S SIGNATURE <u>Margaret R. Englar</u>		24. FUNERAL DIRECTOR ADDRESS <u>C.O. Fuss & Son, Taneytown, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 74 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

11820

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rural, Westminster</i>		<i>50 yrs.</i>		TOWN <i>Rural, Westminster</i>		<i>RD #5</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Westminster RD #5</i>				STREET ADDRESS (If rural give location) <i>Spring Mills</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<i>MARY ETTA STEVENSON</i>				<i>Dec. 31, 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>F.</i>	<i>White</i>	<i>married</i>	<i>Oct. 4, 1877</i>	<i>78</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>house-wife</i>					<i>London Co., Va.</i>		<i>U.S.A.</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Jesse Gelman</i>				<i>Mary Triplett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)						<i>Westminster</i> <i>Mr. John E. Stevenson Rd #5</i>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							<i>6 mo.</i>
592X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Hypertension (Chl)</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Myocarditis (Chl)</i>							
STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 20, 1950</i> to <i>Dec 31, 1955</i> , that I last saw the deceased alive on <i>Dec 30, 1955</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>W. C. Smith</i>				ADDRESS (Street, city, town, state) <i>105 W. Main Westminster Md</i>			
				DATE SIGNED <i>12-31-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Jan. 3, 1956</i>		<i>Widess Cemetery</i>		<i>Rural, Westminster Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<i>Harriet Miller</i>		<i>J. E. Myers Jr.</i>		<i>Westminster, Md.</i>	
DATE <i>Jan 1, 1956</i>							

CERTIFICATE OF DEATH

REG. CHG. NO.

1. DECEASED'S RESIDENCE (HOUSE OR CARE HOME)

2. PLACE OF DEATH

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH
SEX	RACE	CAUSE OF DEATH	IMMEDIATE CAUSE
EDUCATION	RELIGION	PERMANENT CAUSE	PERMANENT CAUSE

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH
DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH	CAUSE OF DEATH

BUREAU V. S.

JAN 4 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE DESTROYED OR DISPOSED OF IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR.

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11817

11821

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>UNION BRIDGE</u>		<u>years</u>		<u>UNION BRIDGE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>STONER ST.</u>		<u>ST.</u>		<u>STONER ST.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN W STRAWSBURG</u>				<u>DEC 16 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>M</u>	<u>AUG 8-1892</u>	<u>63</u> yrs.	Months: <u>1</u> Days: <u>1</u> Hours: <u>1</u> Min: <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LEHIGH CO</u>		<u>POWER HOUSE</u>		<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN W STRAWSBURG</u>				<u>ELIZABETH HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>216-69-0211</u>		<u>CAROLINE STRAWSBURG BRIDGE</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CHRONIC NEPHRITIS</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>HIGH BLOOD PRESSURE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>DATE</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>NO</u>		<u>STONER ST.</u>		<u>UNION BRIDGE</u>		<u>YES</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>12-16-55</u>		<u>M.</u>		<u>2 P.M.</u>			
22. I hereby certify that I attended the deceased from <u>April</u>, 19<u>55</u>, to <u>Dec 16</u>, 19<u>55</u>, that I last saw the deceased alive on <u>12-16-</u>, 19<u>55</u>, and that death occurred at <u>2 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>T. H. L. EGG</u> M.D.				ADDRESS (Street, city, town, state) <u>Union Bridge</u>		DATE SIGNED <u>12-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12/18/55</u>		<u>LUTHERAN</u>		<u>UNIONTOWN MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 12/17/55</u>		<u>Leslie L. Reppe</u>		<u>DDHARTZLER & SONS</u>		<u>UNION BRIDGE</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased

JOHN W. STRAWBURY

2. Sex

Male

3. Date of birth

4. Place of birth

St. John's, Maryland

5. Usual residence

6. Cause of death

7. Date of death

8. Place of death

9. Signature of physician

10. Signature of registrar

11. Signature of medical examiner

12. Name of hospital or institution

13. Name of attending physician

14. Name of informant

15. Name of informant

16. Name of informant

17. Name of informant

BUREAU V. S.

DEC 21 1955

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12-21-55

12-21-55

12-21-55

DEPARTMENT OF HEALTH

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11818

MARYLAND STATE DEPARTMENT OF HEALTH

11822

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>—</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>1921 Linden Ave 3601-4</u>	
TOWN <u>Hampstead</u> LENGTH OF STAY (In this place) <u>—</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		STREET ADDRESS (If rural, give location) <u>Baltimore</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Edith</u> (Middle) <u>Brown</u> (Last) <u>Tawney</u>		4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/6/1913</u>
9. AGE last birthday <u>42</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	13. FATHER'S NAME <u>Clarence Wesley Brown</u>	14. MOTHER'S MAIDEN NAME <u>Bessie Lee Henryman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY No. <u>—</u>	17. INFORMANT <u>Mason Curtis-Reisterstown Md</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

(b)

INTERVAL BETWEEN ONSET AND DEATH

Instant (none)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Gun

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Dec 5 1955 2:50 P.m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Homicide

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1965

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11819

MARYLAND STATE DEPARTMENT OF HEALTH

11823

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 77

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hampstead</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2117 Bolton St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Paul</u>	(Middle) <u>Horner</u>	(Last) <u>Taylor</u>
4. DATE OF DEATH	(Month) <u>Dec</u>	(Day) <u>5</u>	(Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 10 - 1901</u>
9. AGE last birthday <u>54</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mae Wildasin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>180-01-9909</u>	
17. INFORMANT <u>Jacob Harkentine, New Freedom Pa</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Shot gun Wound
of head (Suicide)

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause,
stating the underlying cause last

(c)

INTERVAL BETWEEN
ONSET AND DEATHNone
(Instant)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office, etc.) INJURY <u>gun</u>	(CITY OR TOWN) <u>Hampstead</u>	(COUNTY) <u>Carroll</u>	(STATE) <u>MD</u>
---	--	------------------------------------	----------------------------	----------------------

TIME (Month) (Day) (Year) (Hour)
OF INJURY December 5, 1955 m. 2:50 PMINJURY OCCURRED
While at work ☐ Not while
at work ☒HOW DID INJURY OCCUR? Self inflicted22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>12-5-55</u>	<u>MD Line Cemetery</u>	<u>MD Line</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS
<u>12/5/55</u>	<u>Henry Lewis</u>	<u>Edw Chilton</u>		<u>Hampstead</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 12 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11820

11824

CERTIFICATE OF DEATH

Reg. Dist. No. 82-83

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural-Mt. Airy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>	
TOWN <u>Parrsville</u>		TOWN <u>Parrsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Parrsville</u>		STREET ADDRESS (If rural, give location) <u>Route 4 - Parrsville</u>	
3. NAME OF DECEASED (First) <u>Joanne</u> (Middle) <u>-</u> (Last) <u>Thomas</u>	4. DATE OF DEATH (Month) <u>December</u> (Day) <u>20</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>-</u>	8. DATE OF BIRTH <u>Aug. 6, 1955</u>
9. AGE last birthday <u>4</u> yrs. <u>4</u> mos. <u>14</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Melvin Dewitt Myers</u>		14. MOTHER'S MAIDEN NAME <u>Ada Mae Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Ada Mae Thomas, Mt. Airy, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
571.0 Immediate cause (a) <u>Acute Gastro enteritis of Undetermined etiology</u>			<u>4 days</u>
Antecedent cause(s) (b) <u>-</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>-</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) <u>OF</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from December 17, 1955, to December 19, 1955, that I last saw the deceased alive on Dec. 19, 1955, and that death occurred at 8:45 P. M., from the causes and on the date stated above.

SIGNATURE W.B. Culwell, M.D. (Degree or title) Mt. Airy, Md. ADDRESS Dec. 20, 1955 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>CREMATION</u>	DATE <u>12-22-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Simpson Chapel</u>	LOCATION (City, town, or county) <u>Howard Co. Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>Dec. 22, 1955</u>	REGISTRAR'S SIGNATURE <u>Robert R. Hewitt</u>	24. FUNERAL DIRECTOR <u>G.M. Waltz, Winfield, Md.</u> ADDRESS	

1085356415

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. 4
DEC 23 1955

RECEIVED

11825

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH:

COUNTY

Carroll

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Finckboro

LENGTH OF STAY (in this place)

33 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Finckboro

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

md

COUNTY

Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

Finckboro

STREET ADDRESS

Finckboro

3. NAME OF DECEASED:

(First)

CLARA

(Middle)

SUSAN

(Last)

TRACY

(Type or Print)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Dec 21

1955

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH:

June 28 1879

9. AGE last birthday:

76 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

Id

11. BIRTHPLACE (State or foreign country):

md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Henry J. Steiner

14. MOTHER'S MAIDEN NAME:

Susana Steiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

3 No

16. SOCIAL SECURITY No.:

219-05-64674

17. INFORMANT & ADDRESS:

A. Parker Tracy Finckboro, md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a)

Arteriosclerotic Heart Disease

Interval Between Onset And Death

2 yrs

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO

(b)

Auricular fibrillation

DUE TO

(c)

Congestive Heart Failure

1 MON

2 wks

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 1225, 1955, to Dec 21, 1955, that I last saw the deceased

alive on Dec 21, 1955, and that death occurred at 6.10 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

W. H. Hoand

M.D.

Manchester, Md

12/21/1955

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

12/24/55

NAME OF CEMETERY OR CREMATORY

Fagans Memorial Cemetery

LOCATION (City, town, or county)

Finckboro, Carroll, Md

(State)

DATE REC'D BY LOCAL REGISTRAR

Dec 22-55

REGISTRAR'S SIGNATURE

Mrs. H. P. Steiner

24. FUNERAL DIRECTOR

H. H. H. H.

ADDRESS

Glen Rock, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 28 1955

BUREAU V. S.

11826

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>since 8-30-26</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>unknown</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Justi</u> (First) <u>-</u> (Middle) <u>TUHOMEN</u> (Last)				4. DATE OF DEATH (Month) <u>December</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widower</u>	8. DATE OF BIRTH <u>unknown</u>	9. AGE last birthday <u>64 ?</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Finland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Finland</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Ida Tuhomen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>---</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hebephrenic schizophrenia</u>						<u>more than 29 yrs.</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>---</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>---</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>---</u>			
22. I hereby certify that I attended the deceased from <u>Sept. 1st, 1947</u> , to <u>Dec. 2nd, 1955</u> , that I last saw the deceased alive on <u>Dec. 2nd 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. D. Martin Gross</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>12/5/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		DATE THEREOF <u>DEC 6-55</u>		NAME OF CEMETERY OR CREMATORY <u>U of M. MED SCHOOL</u>		LOCATION (City, town, or county) (State) <u>GREEN ST.</u>	
24. REC'D BY REGISTRAR <u>Dec. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Thur</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Duffel Bros</u> ADDRESS <u>1800 E LOAN BARR ST</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

11282

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE

CERTIFICATE OF DEATH

1900

LOCAL REGISTRAR'S WORKSHEET

PLACE IN DEATH

NAME	AGE	SEX	RACE	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH

CAUSE OF DEATH	DIAGNOSIS	DATE OF DEATH	PLACE OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	DIAGNOSIS

BUREAU V. S.

DEC 8 1900

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

11823

11827

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 50

1. PLACE OF DEATH- COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>New Windsor Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (In this place) <u>years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>New Windsor Rural</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>PAUL</u> (First) <u>BROWN</u> (Middle) <u>WAGNER</u> (Last)		4. DATE OF DEATH <u>Dec</u> (Month) <u>25</u> (Day) <u>1955</u> (Year)			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Dec 1-1893</u>	9. AGE last birthday <u>62</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gonas M Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Etta Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs Norman Condow New Windsor Rural</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>9210 Suffocation - Asphyxiated fig -</u>					<u>minutes</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Hypertension Arteriosclerosis C.V disease</u>					<u>year</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12</u> <u>25</u> <u>5-10</u> <u>10</u> <u>A.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>Asphyxiated fig -</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
SIGNATURE <u>James J. Pharaoh</u>		DEGREE OR TITLE <u>Deputy Medical Examiner</u>		ADDRESS <u>Wheaton Md</u>	
DATE SIGNED <u>12/28/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u>	
LOCATION (City, town, or county) <u>Carroll</u>		(State) <u>Md</u>			
24. FUNERAL DIRECTOR <u>Mr 28</u>		REGISTERAR'S SIGNATURE <u>Ernest Bonedick</u>		ADDRESS <u>Old Fartgler & Sons - New Windsor, Md</u>	

BUREAU V. S.

DEC 30 1935

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completed by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

11772 **CERTIFICATE OF DEATH**

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Westminster</u>		<u>6 years</u>		TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Carroll County Home</u>				STREET ADDRESS (If rural give location) <u>Carroll Co. Home</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Marshall</u> <u>Wetzel</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 5</u> <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Mar. 1, 1875</u>	
9. AGE last birthday <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Hezekiah Wetzel</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Oliver Fleming Woodbury</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.1 IMMEDIATE CAUSE (A) <u>Exhaustion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Progressive</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis</u>				<u>many yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>?</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>He had gangrene in foot</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>?</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.) <u>X</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) <u>X</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>X</u>			
22. I hereby certify that I attended the deceased from <u>10-22</u> , 19 <u>49</u> , to <u>12-5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12-4</u> , 19 <u>55</u> , and that death occurred at <u>2:55</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>W. C. Stone</u>		M.D. <u>Westminster</u>		ADDRESS (Street, city, town, state) <u>Berrett, Carroll, Md.</u>		DATE SIGNED <u>12-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brandenburg</u>		LOCATION (City, town, or county) (State) <u>Carroll, Md.</u>	
24. REC'D BY REGISTRAR <u>12-8-55</u>		REGISTRAR'S SIGNATURE <u>W. C. Stone</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Stone</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>12-8-55</u>							

11887

MARYLAND STATE DEPARTMENT OF HEALTH-WASHINGTON, D. C.

CERTIFICATE OF DEATH

REG. DIST. NO.

1. UNDER RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

BUREAU V. S.

DEC 12 1955

RECEIVED

21007-1-57-1

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR FOR A PERIOD OF FIFTY YEARS. IT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION IN WRITING FROM THE SECRETARY OF HEALTH.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11828

CERTIFICATE OF DEATH

11825

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>1 mo. 29 days</u>		TOWN <u>Silver Spring</u>		<u>1556.2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>10000 Markham Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Elnore WIBLITZHOUSER</u>				<u>12 13 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>12/24/89</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Joseph Dalton</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Dalton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>				16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1 <u>422.1</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>8 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/7/11</u> , 19 <u>55</u> , to <u>12/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/12</u> , 19 <u>55</u> , and that death occurred at <u>4:00A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>12/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>12/15/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		LOCATION (City, town, or county) <u>Arlington Va</u>		(State)	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Cunningham</u>		ADDRESS <u>8434 Ba Ave</u>			
DATE <u>Dec 13, 1955</u>	<u>Sil Sp.</u>						

MB

14228 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11283

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

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BUREAU V. 2

DEC 15 1955

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11829
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. 11826
82/83

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN rural--Mt. Airy</u> LENGTH OF STAY (in this place) <u>8 mo.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>rural--Mt. Airy</u> STREET ADDRESS (If rural, give location) <u>Mt. Olive</u>	
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3. NAME OF DECEASED: (First) <u>BENJAMIN</u> (Middle) <u>N.</u> (Last) <u>WINES</u> (Type or Print)			4. DATE OF DEATH: (Month) <u>DEC.</u> (Day) <u>11.</u> (Year) <u>19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>1875 ?</u>	9. AGE last birthday: <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Chair maker</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>self-employ</u>		11. BIRTHPLACE (State or foreign country): <u>Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME: <u>Elias Wines</u>			14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Fannie Tinsman, Mt. Airy, Md.</u>		

18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Coronary Arteriosclerosis</u> DUE TO Antecedent cause(s) (b) <u>arterio sclerosis</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>34 years.</u> <u>several yrs.</u>
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11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>12-20-51</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Marsh CHIEF MEDICAL EXAMINER ☐ DATE SIGNED _____
 DEPUTY MEDICAL EXAMINER ☒ M. D. ASSISTANT MEDICAL EXAM. ☐ 12/11/55

23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>	DATE THEREOF <u>12-14-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Greenhill</u>	LOCATION (City, town, or county) (State) <u>Berryville, Va.</u>
DATE REC'D BY LOCAL REG. <u>Dec. 13, 1955</u>	REGISTRAR'S SIGNATURE <u>Robert B. Hewitt</u>		24. FUNERAL DIRECTOR ADDRESS <u>Wm. W. Waltz, Winfield, Md.</u>

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.
DEC 19 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **14 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11827

11830

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		LENGTH OF STAY (in this place) <u>YEARS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 BENEDUM ST.</u>				STREET ADDRESS <u>BENEDUM ST.</u>		(If rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>M. ANNIE YINGWING</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 27 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT. 24-1866</u>		9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ELI HANN</u>				14. MOTHER'S MAIDEN NAME <u>DEBORAH STEM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>UNION MRS WILBUR FOWBLE BRIDGE, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
14221 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 23 1955</u> , to <u>Dec 27 1955</u> , that I last saw the deceased alive on <u>Dec 26, 1955</u> , and that death occurred at <u>12 M</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Legg, M.D.</u>				ADDRESS (Street, city, town, state) <u>Union Bridge, MD</u>		DATE SIGNED <u>12-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>DEC 30-55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEM.</u>		LOCATION (City, town, or county) (State) <u>UNION BRIDGE, MD</u>	
24. REC'D BY REGISTRAR <u>See 1/9/1956</u>		REGISTRAR'S SIGNATURE <u>L. P. Keph</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>D. HARTZLER & SONS</u>			
				ADDRESS <u>UNION BRIDGE, MD</u>			

1965

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 15

CERTIFICATE OF DEATH

Form 100-100

IN THE CITY OF BALTIMORE, MARYLAND

DECEASED

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DEC 30 1965

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ENCLOSURE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO ANY PERSON REQUESTING THEM. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF ANY OTHER RECORDS OR FOR THE RESULTS OF ANY INVESTIGATION BASED ON THESE RECORDS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11831

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 11828

No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>X</u> TOWN <u>Sykesville Md.</u>		<u>29 yrs</u>		TOWN <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <u>Bertie</u> (Middle) <u>S.</u> (Last) <u>Youngman</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>?</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>William Youngman</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Russell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Hospital Records</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>Acute Shock</u> DUE TO <u>Extensive scalding of the body by hot water</u>				<u>Min.</u>	
Antecedent cause(s) (b) <u>Diabetes</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Diabetes</u>					
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Schizophrenic Reaction paranoid type</u>					
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>hospital</u>)		21c. (City or town) <u>Sykesville Carroll</u> (County) <u>06</u> (State) <u>Maryland</u>	
21d. TIME (Month) <u>Dec</u> (Day) <u>10</u> (Year) <u>1955</u> (Hour) <u>2</u> M. OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Burned by hot water in tub</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>J. H. Hark</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/10/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>12-13-55</u>		NAME OF CEMETERY OR CREMATORY <u>Bowdon Park</u>	
LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State)		DATE REC'D BY LOCAL REG. <u>Dec. 11, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Ewen</u>	
24. FUNERAL DIRECTOR <u>J. O. Mitchell & Sons - 1900 East Ave. Balt.</u>		ADDRESS			

RECEIVED
DEC 18 1965
BUREAU V. S.

MARYLAND

11832

STATE DEPARTMENT OF HEALTH
11829

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Sykesville, Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4	
TOWN Sykesville, Maryland		TOWN Baltimore City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital		STREET ADDRESS (If rural, give location) -----	
3. NAME OF DECEASED (First) Alois (Middle) (Last) Zephir		4. DATE OF DEATH (Month) 12- (Day) 27- (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 3-26-1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		9. AGE last birthday 52 yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charles Zephir		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Dora Zang		17. INFORMANT AND ADDRESS Hospital records	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) Coronary occlusion		1 hr.
Antecedent cause(s) (b) Myocarditis		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Epilepsy with mental deficiency		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION -----	19b. MAJOR FINDINGS OF OPERATION -----	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) -----	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY -----	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY ----- m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from 1-12- , 19 42 , to 12-27- , 19 55 , that I last saw the deceased alive on 12-27- , 19 55 , and that death occurred at 9:55 A. m., from the causes and on the date stated above.			
SIGNATURE M. N. Mastin, M.D. (Degree or title)		ADDRESS Springfield State Hosp.-Sykesville, Md. DATE SIGNED 12-27-55	
23. BURIAL-CREATION REMOVAL (Specify) 12/31/55	DATE 12/31/55	NAME OF CEMETERY OR CREMATORY CEN. AT FREE	LOCATION (City, town, or county) (State) SAITTO
DATE REC'D BY LOCAL REG. 2-28-55	REGISTRAR'S SIGNATURE W. H. Redlich	24. FUNERAL DIRECTOR W. H. Redlich	ADDRESS FUNERAL HOMES

MARGIN RESERVED FOR BINDING

quantity intensity amount volume

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MS-MSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11833

CERTIFICATE OF DEATH

11830

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Marbleton</u>		<u>6 yrs.</u>		TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Longview Nursing Home</u>				STREET ADDRESS (If rural give location) <u>147 E. Green St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u> (Middle) <u>V.</u> (Last) <u>Zile</u>				(Month) <u>Dec</u> (Day) <u>30</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>white</u>		<u>Widow</u>		<u>Dec 21 1859</u>	
				<u>98</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Abraham Miller</u>				<u>Lidia Falbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Arthur M. Zile, Westminster Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Arterio-Sclerotic Cardiovascular Disease</u>							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>Nov 27</u> , 19 <u>55</u> , to <u>Dec 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>55</u> , and that death occurred at <u>11:41</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Joseph V. E. Burt MD</u>				<u>Westminster Md.</u>		<u>Dec 30, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 2, 1956</u>		<u>Wendover Cemetery</u>		<u>Wendover, Carroll Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan 31-55</u>		<u>Mrs. W. P. S. Sennet</u>		<u>J. E. Myers Jr.</u>		<u>Westminster, Md.</u>	

CERTIFICATE OF DEATH

1933

MASS. REG. NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL

15. SIGNATURE OF INTERMENT

16. SIGNATURE OF FUNERAL

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTRY

20. SIGNATURE OF DECEASED

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